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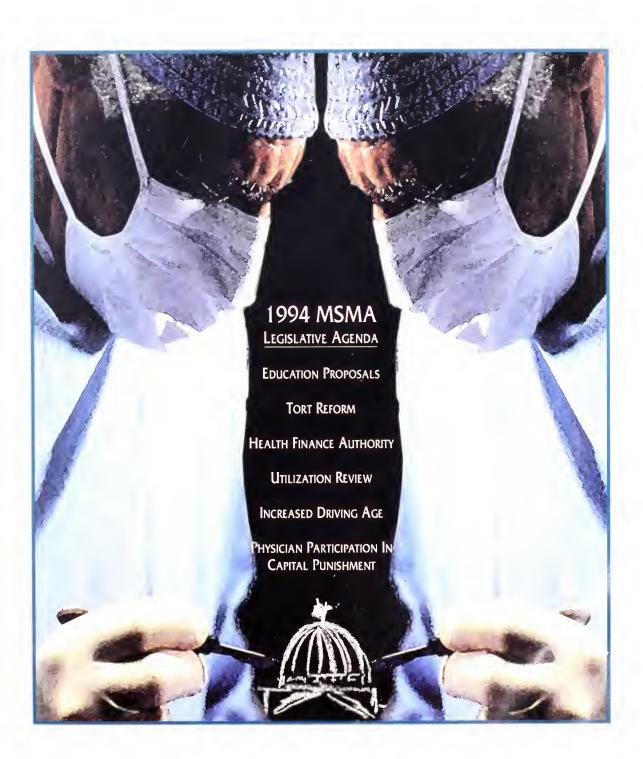
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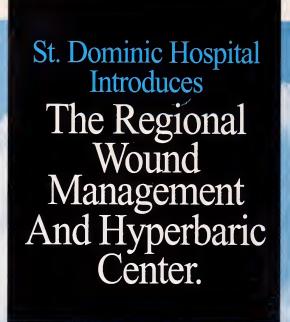
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# JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

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#### Gastric Volvulus and The Upside-down 1 Stomach John A. Johnson, MD and Anne R. Thompson, MD Clinicopathologic Conference IV EDITOR Joe C. Files, MD, Editor Myron W. Lockey, MD **EDITOR EMERITUS** W. Moncure Dabney, MD **EDITORIALS** 12 Like It ASSOCIATE EDITORS George E. Abraham, MD Don Q. Mitchell, MD Leslie E. England, MD **Lottery Fever** 13 Leslie England, MD, Associate Editor MANAGING EDITOR Virginia Lee Cocke DEPARTMENTS PUBLICATIONS COMMITTEE Thad F. Waites, MD. **Medical Organization** 16 Chairman From The University of Mississippi Medical Center 22 William E. Godfrey, MD **New Members** 23 Carolyn Gerald, MD and the editors Deaths 24 **Personals** 25 THE ASSOCIATION **Placement Service** 27 Don Q. Mitchell, MD President Classified 28 Mal G. Morgan, MD President-Elect D. Stanley Hartness, MD Secretary-Treasurer

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### **Dateline**

#### Journal of the Mississippi State Medical Association Volume XXXV, Number 1

#### Tuberculosis: A Class I Reportable Disease

Through proper reporting, Mississippi physicians helped to essentially eliminate tuberculosis strains with acquired drug resistance. From early 1992 and into the latter months of 1993, Mississippi documented no new cases of acquired drug resistant tuberculosis, according to Mississippi State Department of Health records. Together, Mississippi's speedy reporting system and the state's pioneering Directly Observed Therapy initiative are holding local tuberculosis rates steady while national rates explode, said Mike Holcombe, director of the MSDH Tuberculosis Program.

"Directly Observed Therapy is the most significant factor in reducing acquired drug resistance, but prompt reporting is also important", Holcombe said. "We can't treat tuberculosis cases and suspect if they're not reported." Under MSDH rules and regulations governing reportable diseases, physicians must report any confirmed or suspected case of active tuberculosis on first knowledge or suspicion. Tuberculosis is a Class I reportable disease. Class I reports must be made directly to the MSDH Office of Epidemiology, by telephone, with in one working day of first knowledge or suspicion. MSDH keeps all reports confidential.

In November of 1993, state tuberculosis control efforts were temporarily undermined. MSDH uncovered nine diagnosed cases that had not been reported by the attending or consulting physicians. Nationally, studies by the Centers for Disease Control and Prevention show as many as 11 percent of all physicians don't realize they are required to report active tuberculosis. Six percent said they would not report an active case to any public health agency. Essentially, reporting should be the standard of care rather than the exception, Holcombe said. Failure to report in a timely manner puts both the community and the health care staff at an increased risk of secondary tuberculosis cases.

"Reporting allows the State Department of Health to initiate the contact follow-up and provide the necessary intervention to stop the further spread of tuberculosis," he said. "With proper reporting, we can keep those not yet infected from becoming infected and give those who have been infected preventive therapy, when indicated, to reduce their chance of developing the disease."

"That is something that private physicians and even other public agencies do not have the resources or the expertise to do," Holcombe emphasized. MSDH contact follow-up includes skin tests, X-rays, a physician's evaluation, and/or other diagnostic tests.

Although Mississippi claims the ninth highest Tuberculosis incidence in the nation, the state has not suffered the rise in tuberculosis plaguing the rest of the country. Directly Observed Therapy is the main reason why, Holcombe said.

Mississippi undertook DOT as a pilot project in 1985, and by 1987 70 percent of the state's active tuberculosis cases and suspects were receiving directly observed treatment. By 1992, 98 percent were receiving DOT.

(continued)

Rhode Island adopted universal DOT in mid-1993, making it the second state to directly monitor the administration of tuberculosis medicines for all cases. "Several other areas and states are actually starting to implement and increase the numbers on Directly Observed Therapy," Holcombe said. "But in most areas, it's not universal or statewide." The Alabama TB program, for example, has 70 percent of its tuberculosis cases on DOT. South Carolina has approximately 45 percent on DOT, and the city of Atlanta, GA., (Fulton and De Kalb Counties) has about 87 percent.

"Directly Observed Therapy is now a national recommendation, and I think it's in part due to the success we have seen in Mississippi and the awful outbreaks of drug resistant tuberculosis we have seen around the country," Holcombe stressed. "We have been fortunate. We haven't encountered a multiple-drug resistant outbreak recently. However, we are not immune."

MSDH provides free treatment medications through the DOT program, significantly contributing to tuberculosis control efforts. In 1975, Mississippi experienced the first documented person-to person transmission of multiple-drug resistant tuberculosis.

Today, failure to report Class I diseases can result in fines of \$500 and/ or up to six months in jail. In <u>Hall vs. Hilbun</u>, the Mississippi Supreme Court mandated that Mississippi physicians meet the national standard of care. In addition to criminal liability for lapses in reporting, other jurisdictions have held physicians civilly liable when an unreported case spreads.

Other Class I reportable diseases include anthrax in humans, botulism, cholera, dengue, diphtheria, encephalitis, hepatitis A, HIV infection and/or AIDS, measles, meningitis or other invasive diseases due to Neisseria meningitis or Haemophilus influenzae, plague, poliomyelitis, rabies, syphilis, trichinosis, typhoid, yellow fever, and any exotic or rare communicable disease.

Tuberculosis and all other Class I diseases must be reported directly to the Mississippi State Department of Health. To report any Class disease, physicians may call the Office of Epidemiology at 1-800-556-0003. Physicians in the Jackson area may report active tuberculosis cases by dialing 960-7700.

\* \* \*

## UMC In Prostate Project

Jackson, MS — Researchers at the National Cancer Institute in Bethesda, MD, announced that the University of Mississippi Medical Center and 222 other institutions nationwide will participate in the first large-scale prevention trial for prostate cancer. The Prostate cancer Prevention Trial (PCPT), an intergroup study designed to test whether taking the drug finasteride will prevent prostate cancer, will be coordinated by the Southwest Oncology Group (SWOG) and is sponsored by the National Cancer Institute (NCI). Eighteen thousand men age 55 and older will participate. NCI is providing approximately \$60 million to conduct the trial.

"We are embarking on a very important effort," said Dr. Jackson Fowler, director of urology at UMC. "In 1993, there will be about 165,000 new cases of prostate cancer, and about 35,000 deaths. Prevention of cancer is our highest goal, and the need for effective prevention strategies is clear."

A minimum age limit of 55 was selected because older men are at highest risk of developing prostate cancer. About 98 percent of prostate cancers are diagnosed in men 55 or older.

\* \*

## **Original Articles**

## Gastric Volvulus and The *Upside-down Stomach*

John A. Johnson III, MD Anne R. Thompson, MD

astric volvulus is a condition in which the stomach is rotated more than 180° and closed loop obstruction results. Strangulation and gangrene of the twisted stomach may occur, with disastrous results, if this condition is not recognized quickly and emergent surgical detorsion performed.

Ambrose Pare (1579)1 first described a strangulated diaphragmatic hernia with gastric volvulus that developed after a sword wound. Berti (1866)1 reported an acute gastric volvulus found at autopsy of a 60-year-old female who had died quickly from a high closed loop obstruction. Both the duodenum and lower esophagus were obstructed. Berg (1896)1 was the first to operate successfully on a patient with gastric volvulus, after percutaneous decompression with a trocar and cannula. Rosselet1 is credited with the first radiologic description of this unusual entity in 1920.

The case of a 57-year-old female with chronic gastric volvulus in association with a paraesophageal hernia and reflux esophagitis is presented together with a review of the literature.

#### **CASE REPORT**

A 57-year-old female presented to the emergency department with a several month history of substernal and epigastric pain with classic reflux symptoms after each meal. No history of peptic ulcer disease or trauma was elicited. Chest x-ray showed an air-filled retrocardiac density. Barium upper gastrointestinal series indicated an organoaxial volvulus of the stomach (Figure 1) associated with a paraesophageal hernia. Esophagoduodenoscopy at the time of exploratory laparotomy revealed mild esophagitis. Repair of the diaphragmatic hiatal defect and Nissen fundoplication with anterior gastropexy to the abdominal wall were performed. The postoperative course was unremarkable. Followup exam at 6 months shows the patient to be symptom-free.

#### DISCUSSION

The stomach has four ligamentous attachments which maintain its normal position: the gastrosplenic, gastrophrenic, gastrohepatic, and gastroduodenal ligaments. The lowest is the gastroduodenal overlying



Figure 1. Barium gastrointestinal series showing organoaxial volvulus (arrows indicate greater curvature; P equals pylorus).

the second portion of the duodenum, whereas the highest is the gastrophrenic ligament. These peritoneal supports must be lax, elongated or absent in order for volvulus to occur. Gastric fixation is also influenced by the length and mobility of both the lesser curvature and the gastrohepatic omentum.<sup>2</sup>

If the gastrosplenic or gastrocolic ligaments are divided or very lax, the weight of a fluid-filled stomach may cause approximation of the pylorus and cardia, a predisposing factor for volvulus. Congenital or acquired adhesions may form an axis for rotation of the stomach.

Intractable vomiting, rapid increases in intra-abdominal pressure, trauma, and acute gastric dilatation are precipitating factors. Intrinsic lesions of the stomach, such as an ulcer or neoplasm that obstructs or distends the stomach, may initiate gastric volvulus. Extrinsic pressure from adjacent masses or any condition that elevates the left diaphragm (e.g., phrenic nerve paralysis, left lung resection, intrapleural adhesions) may also facilitate development of gastric volvulus.<sup>2</sup>

Anatomic classification is based upon the axis of gastric rotation and distinguishes two main types: organoaxial (Figure 2) and mesenteroaxial (Figure 3). Organoaxial rotation, which is the most com-

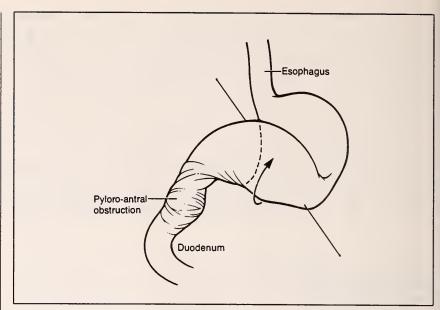


Figure 3. Mesenteroaxial volvulus in which the anterior gastric wall is folded upon itself.

mon type, occurs along the longitudinal cardiopyloric axis. This rotation produces two sites of obstruction, at the cardia and the pylorus. The pyloroantral area can pass anterior (most common) or posterior and is analogous to wringing out a rag.<sup>3,4</sup>

The greater curvature rotates superior to the lesser so that the posterior gastric surface lies anteriorly. Some have theorized that the gas-filled colon ascends, carrying the stomach with it and initiating the twist.<sup>3</sup> This type is usually associated with eventration of the diaphragm or paraesophageal hiatus hernia, as frequently occurs in the *upside-down stomach* seen with a large paraesophageal hernia. Thoracic symptoms with chest pain tend to predominate.

In mesenteroaxial volvulus, the rotary torsion occurs around the transverse axis of the stomach (right angles to the cardiopyloric axis). This type of volvulus is more likely to be idiopathic and partial in extent. The anterior gastric wall is folded upon itself and the cardia is thus separated from the pylorus. Abdominal symptoms predominate in mesenteroaxial volvulus.4 Because the twist is often partial, spontaneous detorsion with recurrent acute episodes is common and strangulation is less likely to occur. A nasogastric tube can usually be passed into the cardia, permitting radiographic visualization of the distended stomach with outlet obstruction.

Gastrointestinal symptoms associated with chronic intermittent gastric volvulus are not well de-

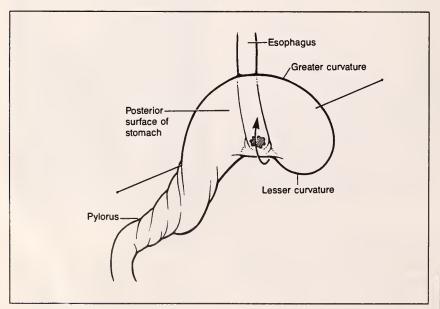


Figure 2. Organoaxial volvulus with anterior rotation and obstruction of both the cardia and pylorus.

fined. Symptoms include: pain during or shortly after meals, which is more frequently associated with liquids than solids, and abdominal distention during or shortly after meals. Diagnosis is difficult, because the symptoms of chronic gastric volvulus may be indistinguishable from those of splenic flexure syndrome, hiatus hernia, or peptic ulcer disease. Additionally, radiologic studies are not always diagnostic, as gastric displacement may be intermittent.5 Often patients are not diagnosed until they develop more severe symptoms during an acute episode.

Borchardt<sup>6</sup> emphasized a triad of symptoms associated with acute volvulus: (1) severe epigastric pain and distention, (2) vomiting followed by violent retching with an inability to vomit and (3) difficulty or inability to pass a nasogastric tube. These symptoms indicate an initial blockage at the pylorus, then at the cardia, and later gastric distention as a closed loop obstruction develops. Incarceration of the stomach is suggested by continued retching without vomiting.<sup>5</sup>

Gastric volvulus is most often seen in adults in the 5th and 6th decades of life although several pediatric series have been reported.7 One third of all patients reported present with acute gastric volvulus; and this condition, associated with acute gastric necrosis from vascular occlusion, accounts for a 30% mortality rate. Strangulation with gangrene of the stomach may occur and is most commonly associated with the organoaxial type. Distinctive features include gastrointestinal bleeding, shock, and acute cardiopulmonary distress. The majority of the reported cases of strangulation occur with diaphragmatic hernia resulting from trauma. Patients may exhibit abdominal complaints including Borchardt's triad as well as thoracic manifestations including substernal pain with radiation, dyspnea, mediastinal shift and possible cyanosis.<sup>2</sup>

#### SURGICAL TREATMENT

Reduction of an acute volvulus, particularly of the mesenteroaxial type (cardia open), may be achieved by a nasogastric tube. When the cardia is obstructed (as in the organoaxial type), a nasogastric tube usually cannot be passed and urgent surgery is indicated.

When operating for acute gastric volvulus, reduction is first accomplished and attention is then directed toward the correction of the underlying condition that may have been a precipitating factor. In adults, the acute volvulus is most commonly caused by a paraesophageal hiatal hernia, as was the case in our patient. Eventration of the diaphragm is the most common cause in infants and children. Gastric necrosis or intrinsic gastric lesions may require local, subtotal, or total resection depending upon the extent.8

Dietel<sup>4</sup> has recommended detorsion of the stomach followed by anterior gastropexy, gastrostomy alone or in combination with gastropexy, partial gastrectomy and/or correction of diaphragmatic defects. Gastrostomy alone is not recommended because, although it fixes the stomach at one point, an additional axis for rotation is created.

Others<sup>3,4,8,9</sup> have also recommended anterior gastropexy as the treatment of choice. Tanner<sup>9</sup> described a procedure in which anterior gastropexy was followed by placement of the transverse colon into the left subphrenic space created when the rotated stomach was reduced into its anatomical site.

Several older techniques have fallen out of current practice. Opolzer's operation is the creation of a stoma between the fundus and antrum as they lie side by side, leaving the stomach in its rotated state. Although this relieves the obstruction, the risk of strangulation still exists. Suture of the stomach to the transverse colon has also been advocated but could be ineffective when the colon is extremely redundant, thin-walled or dilated.

Endoscopic correction of chronic gastric volvulus was first described in 1983. With minimal air insufflation, the endoscope is put in a loop form and counterclockwise or clockwise rotation for 180° is performed. This maneuver results in a sudden jar, indicating detorsion of the stomach. Examination will then show the stomach in a normal position. Although this method has some early success, recurrence is common, and surgery is indicated for definitive treatment.

#### **SUMMARY**

Gastric volvulus may present acutely with Borchardt's triad or with chronic vague abdominal symptoms. Predisposing factors include lax ligaments, bands, adhesions, paraesophageal diaphragmatic hiatus hernia, and eventration of the diaphragm. The goals of surgery are to detorse the stomach, correct conditions associated with volvulus and prevent a recurrence. Anterior gastropexy with or without colon displacement is mandatory. Gastric resection may be required for strangulation and necrosis.  $\square$ 

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Dr. Thompson is Assistant Professor of Surgery and Dr. Johnson was a resident at the time this article was written, both in the Department of Surgery, University of Mississippi School of Medicine, Jackson.

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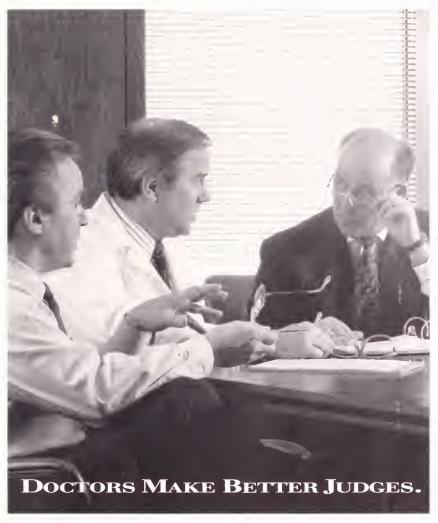
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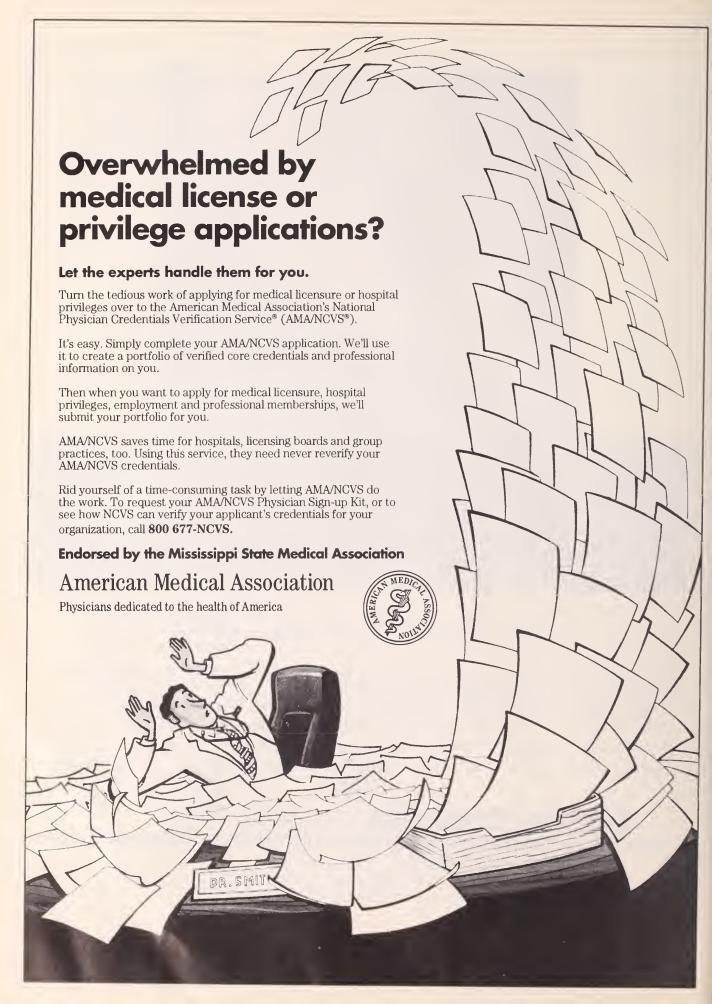
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## CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

#### Clinicopathologic Conference IV

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Differential Diagnosis: Radiological Findings: Pathological Findings: Richard Finley, MD Donna Launey, MD Robert Peace, MD & Warren Johnson, MD

#### CASE PRESENTATION

This is a 53 year old black female with a past medical history of hypertension, non-insulin dependent diabetes mellitus, and Philadelphia-chromosome positive chronic granulocytic leukemia diagnosed in February of 1988. She was followed in Hematology Clinic where she was receiving Myleran intermittently, the last dose being given 10 days prior to admission.

The patient had been relatively asymptomatic except for a brief period, two months prior to admission, when she had symptoms of mild upper respiratory infection. Ten days prior to admission, she developed a papular rash on the extensor surface of her right arm, which was described as two non-pruritic painless lesions. She subsequently developed similar lesions on both arms, both knees and trunk. Two days prior to admission she became febrile with an oral temperature of 102° F. She also reported rhinorrhea which began two days prior to admission, but she denied chills, cough, shortness of breath, chest pain, dysuria, sore throat, otalgia, photophobia, headache, flank pain, or neck stiffness.

There was no history of exposure to children with chickenpox or any other varicella exposure. No one in her immediate family was reported to be ill. There was no history of allergies or exposure to poison ivy. She worked for the Cooperative Extension Service where she inspected homes. Her previous surgeries included an appendectomy and a bilateral tubal ligation, both of which were done many years earlier. She had never smoked and had only rarely consumed alcoholic beverages. She had not traveled out of the state in several years and has never been out of the country. Her medications on admission included enalopril 10 mg per day; glyburide 10 mg b.i.d.; imipramine 75 mg at bedtime. There was no history of rheumatic fever, tuberculosis, tuberculosis exposure, exposure to animals, or HIV risk factors except for a transfusion of one unit of blood in 1986.

On physical examination her oral temperature was 101.9° F, pulse was 120, respiration was 20, blood pressure was 100/64. The patient was a well developed female who did not appear to be acutely ill. She had an asymmetric rash noted on the abdomen, shoulders, lower lip and on all four extremities, particularly the extensor surfaces. There was also one scalp lesion noted. Most of the lesions varied, were papules or plaques and varied in size from .5 to 3 cm. The lesions were primarily reddish-purple in color with some coalescence of the papules to form plaques (Fig, 1). Some plaques were noted to have pustular centers, others appeared to be pustular blisters but they did not appear to be typical vesicular lesions. There were no



Figure 1

lesions of the palms, soles, genitalia, or oral mucosa except for the lower lip lesion. Examination of the head and neck was normal except for one macular lesion with a pustular center on the lower lip. The lungs were clear without abnormality. Cardiac examination was also normal. Abdominal exam revealed normal bowel sounds, a well healed surgical scar and no discernable hepatomegaly or splenomegaly. Geni-

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tourinary examination was normal. A pea-sized node which was mobile and non-tender was palpated in the left axilla. No other adenopathy was noted and there was no cyanosis or edema of the extremities.

Admission Laboratory revealed sodium 132 mEq/ L, chloride 98 Meq/L, potassium 3.4 Meq/L, CO2 combining power of 27 Meq/L, and the BUN and creatinine were 12 and 1.1 mg/dl respectively. The erythrocyte sedimentation rate was elevated at 116 mm/hr, glucose 170 mg/dl, white blood cell count 6.700/mm<sup>3</sup> with 88% segmented neutrophils, 7% lymphocytes, 3% basophils. Uric acid 1.9 mg/dl, calcium 7.9 mg/dl, phosphorus 3.2, total protein 5.7 gm/dl, albumin 3.4 gm/dl, alkaline phosphatase 78 IU/L, total bilirubin 0.4 IU/L respectively. Transaminase were within normal limits, LDH 189 IU/L, CPK 23 IU/L, urinalysis was essentially normal except for 11 white blood cells and 5 red blood cells. Chest radiograph revealed some calcified adenopathy in the right peritracheal region. There was no change compared to any prior films. Sinus x-rays revealed no fluid levels or evidence of sinusitis.

Upon admission, blood and urine cultures were performed and the patient was placed on intravenous Ancef and Gentamicin. Varicella titers were drawn and a Tzanck smear of one of the skin lesions was done. Wound cultures for bacterial and fungal pathogens were obtained from one of the lesions of the left hand. On the fifth hospital day she complained of a painful right eye. She was examined by Ophthalmology who noted a raised vascularized non-pigmented lesion with small cyst-like areas on the conjunctiva just lateral to the iris. Other than some early diabetic retinopathic changes, no additional abnormalities of either eye were noted. Cultures of the eye lesion were taken and the patient was placed on Gentamicin ophthalmic solution for the affected eye.

On the fifth hospital day, the patient continued to develop new lesions similar to those previously described. Varicella titers were reported to be positive at 23 with a positive being greater than 12, but Tzanck smear revealed no giant cells or viral inclusions. All cultures were negative. Syphilis serologies were non-reactive and a tuberculin skin test was negative with a positive *Candida* antigen control. At that time a diagnostic procedure was performed.

Dr. Finley: In summary, this is a 53 year old black female with non-insulin dependent diabetes mellitus, hypertension, and a three year history of chronic myelogenous leukemia. She now presents with a progressive rash and fever for approximately two weeks. She had no other localizing symptoms or signs of infection and her history was not remarkable with

regards to travel or exposure to infectious agents. The rash itself is asymmetrical and involves the extensor surfaces of all four extremities as well as the trunk, scalp, and lower lip. There were no lesions on the palms, soles, mucous membranes or genitals. The rash consists of papules, plaques, and pustular lesions some of which appear almost vesicular. They are reddish-purple in color and the papules in some areas can be seen to be coalescing into larger plaques. (FIG. 1) The patient also a fever of 101.9 °F but the admission physical examination was otherwise unremarkable. The admission laboratory revealed only a an elevated sedimentation rate of 116 mm/hr and a small but abnormal number of cells in the urinalysis including 11 WBC's/hpf and 5 RBC's/hpf.

The differential diagnosis of rash and fever is extensive and includes many infectious and non infectious entities. I will start by considering the infectious etiologies, but before we delve into a long list of possibilities, let us examine the patient herself for any clues as to possible predilections for particular infections. The most obvious condition is leukemia, which automatically indicates a predisposition to frequent and severe opportunistic infections in many physicians' minds. It is important, however, to make the distinction of the type of leukemia before jumping to this conclusion. Our patient has the dubious fortune of having chronic myelocytic leukemia which has been stable for the past 3 years with only intermittent therapy with Myleran. Her WBC count is normal with no blasts and since her hemoglobin and platelet counts are not given I presume they were normal. There is little to suggest, therefore, that she is undergoing a transformation of her CML into a more severe refractory stage. In addition, her uric acid is low and we are given no information to suggest that her recent treatment with Myleran caused a precipitous drop in counts from high levels. The patient apparently still has her spleen since there is no report of splenectomy. In the absence of these factors, the typical CML patient is not particularly predisposed to an excess of infectious complications. The humoral and cellular immune systems are intact and the neutrophils which are present are mature and function normally.

The patient also has non-insulin requiring adultonset diabetes mellitus which has been well controlled with an oral hypoglycemic agent and her blood glucose on admission was 170 mg/dl. There have been some *in vitro* studies showing phagocytic abnormalities caused by markedly elevated glucose concentrations and we are all familiar with the predisposition of patients with severe hyperglycemia or ketoacidosis to infections such as mucormycosis or sepsis. In addition, diabetics often develop local vascular and neuro-

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logic complications that predispose them to various infections such as diabetic foot infections and osteomyelitis. In general, however, for a well-controlled diabetic such as our patient, there is little if any increased risk of infection. Our task would be made more difficult if we were told that the patient had just returned from Tucson or the jungles of South America, or that she was surrounded by a menagerie of exotic animals, but in this case there is no history of any environmental, travel, social, occupational, or exposure history which would place her in a higher risk group for other infections. She did receive a blood transfusion in 1986, but at this time blood was already routinely checked for HIV seropositivity and, thus, she was at low risk of acquiring HIV infection.

From the point of view of infectious diseases, then, as a first approximation we can consider this woman to be a previously normal host infected with an unknown pathogen. In order to maintain a coherent train of thought, we can divide these roughly into bacterial, viral, fungal, and parasitic infections which we will discuss in turn.

Bacterial infection is always a possibility and obviously this was considered likely by the treating physicians since the patient was placed on broad-spectrum antibiotics almost immediately. What bacteria could be responsible? Certainly staphylococci and streptococci are frequent pathogens in skin and soft tissue infections and we might consider a pyoderma if the condition were more localized. It would be difficult to explain the widely disseminated lesions on this basis, however. There is no report of a gram stain being done on the lesions which is unfortunate since this is a simple but extremely valuable examination whenever a bacterial etiology is suspected. Bacterial cultures were subsequently negative and that makes this diagnosis unlikely. Chronic meningococcemia is a rare disease that presents with diffuse skin lesions varying from maculopapular evanescent rashes to frank purpura, but our patient's rash had no hemorrhagic component and her blood cultures were negative. Disseminated gonococcal infection usually presents with sparse lesions that appear with a violaceous or erythematous border and a pustular center and are usually painful. They are rare on the trunk and although we are given no sexual history for the patient or results of a gonococcal culture, the clinical picture is not compatible with this diagnosis. Similarly, the lesions are not typical of secondary syphilis, but syphilis has always been known as the great masquerader and should always be considered in any atypical skin eruption. Our patient had a negative serology for syphilis which essentially rules this out as a diagnostic possibility. Mycobacterium tuberculosis can present with a variety of skin lesions

varying from cold abscesses to maculopapular rashes with the latter more frequent in miliary disease. Our patient has no history of recent weight loss, night sweats, or TB exposure and she has a negative TB skin test and chest X-ray so we will eliminate it from consideration. The lesions of non-tuberculosis mycobacterial infection are generally more indolent, localized, and indurated and do not have the appearance of our patient's rash. Nocardia species can certainly cause a disseminated cutaneous infection but it is usually seen in the setting of an immunocompromised host in the presence of pulmonary nocardiosis. It is characterized by a more slowly developing soft tissue swelling with subsequent ulceration and is unlikely to present in the dramatic fashion seen with the rash in our nonimmunocompromised patient.

The most common viral infections to present with vesicular or bullous lesions are varicella-zoster and herpes simplex infections. Disseminated zoster or herpes simplex presenting in this manner would not occur in an immunocompetent host. A primary varicella infection (chickenpox) in an adult can be a severe infection and would be a consideration, but there are several things that lead us away from this diagnosis. Chickenpox is usually preceded by a prodrome and the rash spreads from the trunk to the extremities. In our patient, the rash first appeared on the extremities and only later involved the trunk. Further, the fever appeared only after the rash had been present for over a week. Add to this the high varicella antibody titer indicating previous exposure to varicella, the negative Tzanck smear, and negative viral cultures of the lesions and it is clear we must look elsewhere for the diagnosis. Atypical measles is a syndrome that occurs in partially immune individuals, frequently due to exposure to the early vaccines, who then appear to have a severe hypersensitivity reaction to infection with the measles virus. This can appear as a severe vesiculobullous rash as in our patient, but usually the rash is preceded by fever and malaise and these patients are very ill, neither of which was the case in our patient. Coxsackie and enteroviral infections can present with a vesicular exanthem but they are usually mild and self-limiting and do not have the appearance of the rash in our patient.

We will make short work of fungal and parasitic infections. Our patient is not significantly immunocompromised, so she is unlikely to have disseminated *Candida*, *Aspergillus*, or *Cryptococcus* infection; although they can certainly all cause severe cutaneous disease in the proper clinical setting. Our patient's lesions do not resemble the more typical ulcerations of cutaneous histoplasmosis. Atypical blastomycosis could be a possibility but the appearance

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of the lesions and the rapidity with which they developed speaks against this. Examination of a saline wet prep of the lesion should have easily shown the characteristic thick-walled budding yeast forms in this case. Similarly, cutaneous sporotrichosis is a more indolent and is usually a localized ulceronodular process quite unlike that of our patient. She has no travel history to suggest coccidioidomycosis or paracoccidiodomycosis and the acute course also makes these diagnoses untenable. There is absolutely no epidemiologic or clinical evidence to suggest a parasitic etiology such as leishmaniasis. The only parasite one might give any consideration to, particularly if our patient was immunocompromised, is an ectoparasite, namely scabies. It can occasionally present a diagnostic dilemma in the overwhelming form known as Norwegian scabies, but it is quite pruritic and should not cause the high sedimentation rate and fever seen in our patient. I will now consider some non infectious etiologies for this patient's clinical presentation. Erythema multiforme is a syndrome due to the deposition of immune complexes in the skin with resultant inflammatory changes and presenting as a diffuse symmetrical erythematous rash, often appearing on the palms and soles, and usually with some lesions showing a characteristic target configuration. It may be idiopathic or associated with viral infections or drug hypersensitivity reactions. A severe potentially fatal form known as the Stevens-Johnson syndrome is associated with mucous membrane lesions, bullae formation, and ulceration. Our patient's rash did not exhibit the characteristic target lesions of erythema multiforme so I will exclude this diagnosis for now. Porphyria, particularly porphyria cutanea tarda can present with extensive erythematous bullous disease and can occasionally show pustular changes. It is more common in males, is often associated with alcohol abuse and liver dysfunction, and most often occurs only on sun exposed surfaces such as the arms and head. Our patient had none of the associated risk factors and the distribution of lesions would not be consistent with this diagnosis. The patient also does not show the characteristic linear vesiculation of poison ivy dermatitis and she reported no suspicious exposures. The appearance and distribution of the lesions would make other forms of contact dermatitis unlikely.

There are two disorders which more closely fit the clinical presentation of our patient, one of which I think probably represents the underlying disturbance in this case. Vasculitis in general and cutaneous vasculitis in particular is characterized by the vascular deposition of immunoglobulin, immune complexes, or complement components with a consequent perivascular infiltration of polymorphonuclear leukocytes and mac-

rophages leading to necrosis of the vessel walls. the skin, this presents clinically with the classical findings of palpable purpura, but in severe forms it can also present with bullae formation, pustules, and ulcerations. It may be seen in many disorders including systemic lupus erythematosus, rheumatoid arthritis, cryoglobulinemia, mixed connective tissue disease, Behcet's disease, polyarteritis nodosum, Wegener's granulomatosis, drug reactions, malignancy, or infection. The overall clinical presentation of our patient is certainly compatible with this diagnosis and her markedly elevated erythrocyte sedimentation rate and active urinary sediment would be additional supportive factors. The most likely underlying etiology would be a drug-related vasculitis or a vasculitis associated with her underlying malignancy. The immune derangements that lead to vasculitis are in general poorly understood.

A second entity which would even more closely fit our patient's presentation is that of acute febrile neutrophilic dermatosis which was first defined by Sweet in the early 1960's, although it had been recognized much earlier. It is a dermatosis that is frequently associated with malignancy, acute leukemias being the most common followed by myelofibrosis syndromes and chronic leukemias. It has been associated with CML as in our patient. It has also occurred in association with drug reactions, Crohn's disease, and in otherwise normal hosts. It presents with the onset of purplish plaques which occur primarily on the extremities and face, occasionally on the trunk, and rarely on the mucous membranes. The lesions rapidly coalesce to give the appearance of mountain ranges. They are occasionally pruritic and frequently painful and may progress to form vesicular lesions or even pustules. Histopathology reveals a dense dermal infiltration of neutrophils with perivascular accumulations of PMN's but no true vasculitis or fibrinoid necrosis. The clinical picture is associated with fever in approximately 80% of cases but, despite the name, is associated with a peripheral neutrophilia in only 30% to 50% of cases. The erythrocyte sedimentation rate is usually elevated. It is very important to make a specific diagnosis in this case because this condition is treatable and usually responds rapidly to steroids with complete resolution.

In view of the clinical presentation and appearance of the rash in our patient along with the associated fever and underlying CML, I think that the diagnostic procedure performed was a skin biopsy which showed the typical histopathologic findings of Sweet's syndrome (acute febrile neutrophilic dermatosis). The finding of a cutaneous vasculitis would be a good alternative possibility.

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Diagnosis: Sweet's syndrome

(acute febrile neutrophilic dermatosis)

Pathology: Received is a skin biopsy.

The specimen is an adequate sample of skin and dermal tissue with associated subcutaneous fat. The dermis is densely infiltrated with massive numbers of polymorphonuclear cells. There is no vasculitis or necrosis associated with the infiltration of the dermis or the perivascular tissue. This is consistent with Sweet's syndrome.  $\square$ 

2500 North State Street Jackson, MS 39216

- Dr. Files is Professor of Medicine and Associate Chairman for Clinical Affairs, Department of Medicine; Dr. Finley is Assistant Professor of Medicine, Department of Medicine; Dr. Launey is Chief Resident in Radiology, Department of Radiology; Dr. Peace is Associate Professor of Pathology, Department of Pathology and Dr. Johnson is Professor of Pathology, Department of Pathology, all at the University of Mississippi Medical Center.
- Dr. Adkins, Dr. Rees, and Dr. Simeone were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1991-92.

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The President's Page DON Q. MITCHELL, MD

#### Like It

"Take care to get what you like, or you will be forced to like what you get."

— George Bernard Shaw

The Mississippi Legislature convened on Tuesday, January 4th of this new year. There are several MSMA initiatives in this legislative session that merit your active support.

We will urge the Legislature to enact the recommendations of the Governor's Health Care Commission, which include the following tort reforms:

- 1. Limit awards for non-economic damages at \$250,000.
- 2. Permit introduction of evidence concerning collateral sources of payment. (A "collateral source" is any compensation for injuries a patient receives such as from health or disability insurance.)
- 3. Change the statute of limitations to provide that a suit must be brought within two years from discovery of the incident, but in no case longer than five years.
- 4. Limit plaintiff attorney contingency fees to no more than 25% of the first one million and 20% to any amount over that. (A reasonable limit on attorney contingency fees ensures that a greater portion of the award goes to the injured patient rather than to cover attorney's fees.)

Most of these liability reform recommendations are based on California's Medical Injury Compensation Reform Act of 1975, known as MICRA, which has helped reduce malpractice liability insurance premiums in California from the highest in the nation to below the average for all states. Their premiums are now one-half to one-third of those in high population states which have not adopted MICRA reforms and patients continue to receive adequate compensation for injuries.

(Continued on page 14)

### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 1 JANUARY 1994

#### **Lottery Fever**

Several weeks ago I was driving with my daughter to New Orleans and as we approached I-55 I asked her if she wanted to stop for a soft drink. Was Louisiana far? She wanted to know. I told her it wasn't. Well, she pointed out, if we stopped in Louisiana we could buy a Lotto ticket along with the drink. One Lotto ticket and five scratch off cards later we had a five dollar winner and made another stop to buy five more tickets with the winnings. We wound up with nothing, though we had had our chance at the big bonanza.

Lottery fever is sweeping the country. Many states have them now. Here in Natchez we have a casino with blackjack, roulette, poker and slots. Ads appear regularly in the *Democrat* showing the beaming faces of \$10,000 and \$25,000 winners.

And there are even bigger winners. Recently a jury out west awarded a man millions of dollars in damages after he was shot in the back by a policeman while fleeing a crime. A few in the press decried this transfer of money, but by and large the public received the news quietly in the due course of events.

In December a van pulled into Natchez preceded

by a hail of ads offering testing for asbestosis. People flocked down to stand in line for the free tests. One of my patients who went told me that when he asked the personnel on the van who had arranged for this public health endeavor, he was informed that it was a group of attorneys.

My point is this. We live in a lottery society now, and every year the trend grows stronger. The lottery, or lawsuit, is an off beat form of socialism, a way for a few to make a great financial gain that would otherwise be impossible or take years of labor to accrue. A politician takes the lottery away from people only at his great peril. Placing caps on the winnings is not popular either.

We have worked for years for liability relief. Reasonable damages are one thing, but funding the jackpot of the Lotto is another. The politicians have guarded liability relief as they have no other concession. If we are forced to dicker for something in exchange for imposition of price controls, look for liability relief to be offered to us last, or not at all.

Leslie E. England, MD Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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(Continued from page 12)

Once again we will attempt to persuade the legislature to enact a law permitting access to the criteria and standards employed by utilization review agents to make medical necessity determinations.

And, as directed by the MSMA House of Delegates during the 125th Annual Session, we will also seek to have the minimum age for a driver's license increased from 15 to 16.

Our legislative plate for 1994 is very full. We need your active involvement if we are to be successful. It is our personal calls and conversations with legislators that will make the difference. I urge you to participate in this legislative session because if we don't take the time to see that these and other health care issues are properly addressed in a manner that is favorable to medicine, then we most certainly will be forced to live with what we get.

As the health system reform debate continues and this legislative session begins, I hope that medicine will be allowed to continue to do its job.... not have the system do a job on medicine.

Your colleague,

Don

MSMA 126th Annual Session May 11 - 15, 1994 Ramada Renaissance Jackson, MS

## YOCON® YOHIMBINE HCI

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.  $1.3.4\,$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $\frac{1}{2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks. 3

How Supplied: Oral tablets of Yocon\* 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## **Medical Organization**

## MSMA Board Conducts Fall Meeting

MSMA's Board of Trustees conducted its Fall meeting in Jackson on December 11. Among reports and actions considered by the Board were:

- A report on current activities of the MSMA Alliance (formerly MSMA Auxiliary).
- Approval of the 1994 Budgets for MSMA and its affiliated organizations.
- Recommendations from the MSMA Council on Legislation concerning health legislation to be considered by the 1994 MS Legislature.
- A report from MSMA's delegates to the AMA House of Delegates.
- Programs for the 1994 Health Issues Seminar (January 18, 1994) and 1994 MSMA Annual Session (May 11-15, 1994).
- A report on the Medicaid Case Manager Program (Health Link).
- Reports on activities of the MS Foundation for Medical Care, MS Board of Medical Licensure, MS State Board of Health, Medical Assurance Company of MS and MS Disabled Physicians Program.

The Board of Directors of the Physician's Insurance Company also met on the same date and received reports on current and future operations of the company.

## Health Care Town Hall Meeting Held in Jackson

Mississippi State Medical Association and Mississippi Hospital Association were sponsors for a Health Care Town Hall Meeting held recently at St. Dominic Hospital in Jackson.

Mississippi Senator Trent Lott, at far right, and Texas Senator Phil Gramm, left, were present for the discussion of health care reform alternatives.

This forum was part of Senator Gramm's nine state tour meeting with people interested in health care reform. A crowd of over 300 business executives, representatives of health insurance companies, hospital administrators and health care professionals attended the two hour session.

Key issues discussed were, portability of health care, universal coverage, cost controls and payment for coverage. □



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## U. S. Rep. Gene Taylor Visits with Hattiesburg Physicians

Mississippi Representative Gene Taylor recently spent time with Hattiesburg physicians and others discussing President Clinton's health-care reform plan.

Representative Taylor visited Hattiesburg area hospitals and clinics to help him decide how to vote on Clinton's Health Reform Plan. Rep. Taylor said he does not support Clinton's plan. "Clinton is like a ball of putty, he will change that bill up until the final vote to try to please everyone. At the end, I won't know what I'll be voting on."

Rep. Taylor said the bill is too comprehensive. "The state address-

es problems one thing at a time. Congress, for the worst, tends to lump everything together. Lumping them togther is the mistake we're making with health care," Taylor said.

Small business and the deficit will suffer the most from Clinton's health plan, Taylor said.

"We're already spending 10 times more on medicine than on the welfare system," he said. "We spend 28 billion on welfare and over 300 billion on medicine. And with Clinton's plan, we'll have to find \$300 billion new dollars to fund it."

"Much of the cost of medicine comes from ever increasing medical equipment and supplies, doctors and hospitals trying to outdo each other, the increasing cost of living and a nation of aging residents," Taylor said.



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## Dr. Pamela Jett Named MBS Medical Director



Mississippi Blood Services (MBS) announces the appointment of Pamela L. Jett, MD, as Medical Director.

Dr. Jett's area of responsibility includes: providing guidance in all medical aspects of blood services and patient services; assuring conformity with American Association of Blood Banks, Food and Drug Administration, Occupational Safety and Health Administration, and

other applicable regulations concerning blood and patient services; and serving as the liaison between MBS and the medical community.

Prior to joining MBS, Jett was a staff member at Parkview Regional Medical Center where she served most recently as Medical Director of Laboratories and was a former Staff Pathologists.

In addition to being certified by the American Board of Pathology in Anatomic and Clinical Pathology, Dr. Jett is a member of the American Association of Blood Banks, American Medical Association, American Society of Clinical Pathologists, College of American Pathologists, Mississippi Association of Pathologists, Mississippi State Medical Association and Central Medical Society.

Dr. Jett completed her residency in Anatomic and Clinical Pathology at the University of Florida College of Medicine and holds a doctor of medicine degree from the University of Louisville School of Medicine.

### American Academy of Pediatrics



## Smoking, Drinking & Children

Substance abuse takes many forms and has many effects—all of them bad. We hear about the costs in terms of lost work hours and dollars spent on treatment programs. We don't always hear about the effects of substance abuse on America's most vulnerable population—our children.



The American Academy of Pediatrics is working to combat substance abuse. As part of the effort, the nation's 45,000 pediatricians have declared October as Child Health Month. Join us this month as we speak up for children. Help us place solutions before problems.

- The truth about smoking. Twelve million American children under age 5 may be exposed to second hand smoke. A recent EPA study finds that second hand smoke may cause as many as 300,000 respiratory ailments in children. If you smoke, quit. If you can't quit, don't smoke around children.
- The facts about alcohol. Five thousand babies are born each year with fetal alcohol syndrome—a birth defect that could be prevented by abstaining from drinking during pregnancy. The average age at which children have their first drink is 12. It's no surprise then, that 4 to 5 million young Americans are problem drinkers.
- Advertising plays a role. Talk to your kids about how they are being influenced.

For more information, send a stamped, self-addressed envelope to: Substance Abuse, Dept. C, American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60009-0927.

#### NOTICE!!

The MSMA Alliance Raffle
(Trip to London)
for AMA-ERF was not held on
December 24th.

Tickets are still available from your local Alliance Members.

## **Component Societies**

Dr. A. Jerald Jackson, of Hattiesburg, above, concluded his year as president of South Mississippi Medical Society at the December meeting.

Dr. John M. Wallace of Laurel was installed as the incoming president of the society.

Guest speaker for the meeting was MSMA President Dr. Don Mitchell, at far right, Among those participating in the meeting were Drs. Hilda and George McGee, at left.



Kathy Fletcher, above left, wife of Dr. Jeff Fletcher, is currently serving as president of Central Medical Society Alliance.

Dr. John Cook, immediate past president, at left, presents gavel to new Central Medical Society President, Dr. Mickey P. Wallace, at right.

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## APA Honors Dr. Tourney With Library Room

The Board of Trustees of the American Psychiatric Association (APA) this fall named the new rare books room in the Library and Archives in honor of Garfield and Helen W. Tourney, two individuals who have been long-time supporters of the Library.

Dr. Tourney has been professor of psychiatry and human behavior at the University of Mississippi Medical Center since 1978 and was appointed Professor Emeritus in July 1992.

This new facility in the APA's Library is fast becoming a recognized national resource for the study of the history of mental illness and its treatment, and psychiatry.

Dr. Tourney is a life fellow of the APA and a member of the Committee on History and Library since 1984. In the late 1980's, Dr. and Mrs. Tourney began contributing additional rare books that have enhanced the value of the collection as a first rate resource for the study of the history of psychiatry and mental illness.

It was through their interest and commitment to developing the rare books collection into a major resource of the APA Library that the APAs Committee on History and Library began the fund-raising campaign to build and endow the Garfield and Helen W. Tourney Rare Books Room.

The room will be open to scholars and researchers with an interest in the study of the history of mental illness and its treatment.

COMMENTS or QUERIES....

The Editors of Journal MSMA invite you to comment on any material that appears in or is absent from the publication.

If you have a query or comment, please send it to:

The Editor, Journal MSMA, PO Box 5229, Jackson, MS 39296-5229

#### Mississippi Psychiatric Association Holds Winter Meeting

The Mississippi Psychiatric Association (MPA) held its Winter Meeting December 3-5 in Natchez. Approximately 40 physicians, spouses and guest attend the meeting at the Eola Hotel.

Guest speakers for the session included: Dr. Angelos E. Halaris, chairman, Department of Psychiatry, University of Mississippi Medical Center; Albert Randel Hendrix, PhD, executive director, Mississippi Department of Mental Health and Nicholas M. Meyers, assistant director of government relations, American Psychiatric Association.

A general membership meeting was also held in addition to the scientific and socio-economic program.  $\Box$ 



Mississippi Psychiatric Association 1993-95 officers are from left: Susan Younger, MD, secretary; Pat Ainsworth, MD, president; Diane K. Little, MD, president-elect and J. Ed Ruff, MD, treasurer.

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## The University of Mississippi Medical Center



#### Wicker Professorship

Carrol Wicker of Hattiesburg, wife of the late Dr. Ralph T. Wicker, center, presented gifts totalling \$100,000 to the Ralph T. Wicker Professorship in Spinal Cord Injury in the Department of Neurosurgery at the University of Mississippi Medical Center in Jackson. Accepting the checks are Dr. Norman C. Nelson (left), UMC vice-chancellor for health affairs, and Dr. Robert R. Smith (right), UMC chairman of neurosurgery. The professorship, established by the generosity of the Wicker family and friends, was created to assure that the UMC School of Medicine could recruit an outstanding physician scientist who has special expertise and special interest in spinal cord injury.

#### **Purks Scholarship**

Melvin Hank Seid of Vicksburg is the first recipient of the William K. Purks Merit Scholarship at the University of Mississippi Medical Center in Jackson. The scholarship, funded by the Vicksburg Hospital Medical Foundation, honors Dr. William K. Purks of Vicksburg,

Seid, a third-year medical student at UMC, was born and raised in Vicksburg where he graduated from Warren Central High School with many academic honors. He worked for four summers with the U.S. Army Engineers Waterways Experiment Station as a science and engineering trainee. His work in scientific visualization sparked an interest in how the technology could be applied in medicine. Seid graduated from the University of Mississippi with a 4.0 GPA before enrolling in the school of medicine. 



At Purks Scholarship presentation: from left, Dr. Norman C. Nelson, UMC vice chancellor for health affairs; Dr. William K. Purks, of Vicksburg; Melvin Hank Seid, scholarship recipient; and Dr. R. Gerald Turner, chancellor of the University of Mississippi.

\_

## **New Members**

Broussard, Isaac D., McComb. Born Baton Rouge, LA, September 25, 1954; MD, Louisiana State University School of Medicine, Shreveport, LA, 1981; pathology residency Brooke Army Medical Center, 7/81 - 6/85; elected by South Central Medical Society.

Byers, Mlchael R., Jackson. Born Austin, TX, February 28, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; internal medicine residency, UMC, 7/89 - 6/90; infectious disease fellowship, UMC, 1990-92; elected by Central Medical Society.

Carter, W. Larkin, III, Jackson. Born Meridian, MS, July 30, MD, Emory University School of Medicine, Atlanta, GA, 1989; radiology residency, University of Texas Southwestern Medical School, Dallas, TX, 1989-93; elected by Central Medical Society.

Evans, Roy D., Jackson. Born Grenada, MS, January 4, 1946; MD, University of Arkansas School of Medicine, Little Rock, AR, 1988; interned one year Methodist Central, Little Rock, AR; emergency medicine residency University of Missouri, 1989-90; elected by Central Medical Society.

Hays, Richard Paul, Biloxi. Born Lee County, MS, July 7, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1979; interned and radiology residency, Baptist Memorial Hospital, Memphis, TN, 1979 - 83; elected by Coast Counties Medical Society.

Hughes, Vernon Thomas, Jr., Clarksdale. Born Clarksdale, MS, July 2, 1952; DO, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1992; interned on year Greenbrier Valley Medical Center, Fairlea, WV; elected by Clarksdale & Six Counties Medial Society.

Jones, VlacIn Faeza, Vicksburg. Born Youngstown, OH, February 26, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; pediatric internship and psychiatric residency, University Medical Center, Jackson, MS, 1989 - 1993; elected by West Mississippi Medical Society.

Pennington, Roy David, Summit. Born Mobile, AL,

December 7, 1954; MD, University of South Alabama School of Medicine, Mobile, AL, 1989; anesthesiology residency, Same, 1989-93; elected by South Central Medical Society.

Pepllos, Salvador N., Marks. Born Philippines, October 14, 1931; MD, Manila Central University, 1956; interned one year Manila Central University and Affiliated Hospitals; interned one year Griffin Hospital, Derby, CT, 7/71-6/72; surgery residency, Englewood Hospital, Englewood, NJ,1972-76; full time emergency room surgeon, 1976-78, Dept. Surgery, Jersey City Medical Center, Jersey City. NJ; fellowship in Thoracic and Vascular Surgery, Deborah Heart & Lung Center, Browns Mills, NJ, 1978-80; elected by Clarksdale & Six Counties Medical Society.

Terral, Thomas Gregory, Jackson. Born New Orleans, LA, November 25, 1961; MD, Louisiana State



**JANUARY 1994** 

#### **New Members / continued**

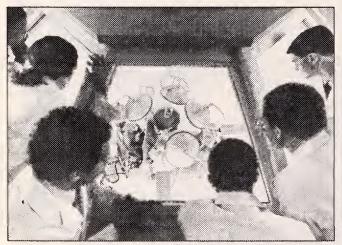
### **Deaths**

University School of Medicine, New Orleans, LA, 1987; orthopaedic surgery residency, University Medical Center, Jackson, MS, 1988-92; one year fellowship, Institute Bone & Joint Disorders, Phoenix, AZ; elected by Central Medical Society. □

CORRECTION: DECEMBER ISSUE - PAGE 433 Ellison, Parker L., Jackson. Born San Francisco, CA, October 13, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1990; residency in pediatrics, Vanderbilt University School of Medicine, Vanderbilt Hospital, Nashville, TN, 1990-93; elected by Central Medical Society.

Fabbricante, Salvatore P., Jackson. Born Brooklyn, NY, June 17, 1911; MD, Royal University School of Medicine, Palermo, Italy, November 1935; internship one year, Greenpoint Hospital, Brooklyn, NY, 1946-47; died November 30, 1993, age 82. □

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## **Personals**

J. Phil Balaski has associated with MEA Medical Clinics in Laurel, 1515 Jefferson St.

Robert J. Berg, of Meridian recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Jeff Anderson Regional Medical Center.

Walter M. Burnett has associated with MEA Medical Clinics at the Reservoir Clinic, 504 Grants Ferry Road, Brandon.

**Robert L. Crocker** has associated with MEA Medical Clinics at the Reservoir Clinic, 504 Grants Ferry Road, Brandon.

C. Ralph Daniel, III, of Jackson conducted a forum on fungal infections and nail disease in Washington, DC. in early December.

Kenneth Gaines has associated with Baptist Memorial Hospital-North Mississippi in the practice of Neurology, 2301 South Lamar, Oxford.

William M. Grantham of Jackson has associated with MEA Medical Clinics at the South Clinic, 1777 Ellis Avenue.

George G. Hamilton of Jackson was recently elected the 1993-1994 President of the Southern Psychiatric Association during its annual meeting recently held at the Castle





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## Physicians' Recognition Award

### I I

Nine MSMA members were named recipients of the AMA Physicians Recognition Award in November 1993. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY
Cynthia Elaine Allen, MD
Virgil Isaac Aultman, MD
Thomas P. Mills, MD
Louis J. Wise, MD

COAST COUNTIES MEDICAL SOCIETY Sidney Albert Chevis, MD

East Mississippi Medical Society Robert Wylie Jarrett, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY Thomas L. Sweat, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY
John Malcom Beaman, MD
Hien Van Phan, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

#### Personals/continued

Harbor Hotel in Bermuda.

Paul Douglas Jackson of Greenville has been certified as a Diplomate of The American Board of Obstetrics and Gynecology, Inc.

Hilda J. McGee of Hattiesburg announces the opening of her office for the practice limited to office gynecology, 5003 Hardy Street, Wesley Towers, Suite 300, Hattiesburg.

Don Q. Mitchell of Jackson was elected treasurer of the American College of Allergy and Immunology (ACAI) during the ACAI's annual business meeting held recently at the Atlanta Marriott Marquis Hotel.

Mitchell J. Myers announces the opening of his office for the practice of neurology, 2500 Fifth Street North, Columbus.

Martin M. Newcomb of Jackson recently received a threeyear appointment as Cancer Liaison Physician for the Hospital Cancer Program at Methodist Medical Center.

Charles Ray Parker of Corinth has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Buddy Savole of Jackson was a guest speaker at the Interior Symposium on Arthroscopy of the Shoulder, Elbow and Wrist in Mulhin on Rhur, Germany.

Geri L. Weiland of Vicksburg is president-elect of the University of Mississippi Medical Alumni Chapter.

Armie W. Walker has associated with Vicksburg OB-Gyn Associates for the practice of obstetrics and gynecology, 1203 Mission Park Drive, Vicksburg. □

Send Items for the Personals Column

to the Editor, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229

# **Placement Service**

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**VOLUME XXXV** 

NUMBER 2

# **SCIENTIFIC ARTICLE**

Total Abdominal Colectomy For Control Of Massive
Lower Gastrointestinal Bleeding
Richard J. Field, Sr., MD; Richard J. Field, Jr., MD
and Stacy Shackleford, BS

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# **Dateline**

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Volume XXXV, Number 2

# 126th Annual Session Scientific Exhibits

The MSMA 126th Annual Session will be held May 11-15, 1994 at the Ramada Plaza Hotel, 1001 E. County Line Road, Jackson, MS. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or Fax the following information to (601)352-4834.

### The request for exhibit space should include:

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- (3) an estimate of the amount of exhibit space needed (MSMA will provide a table only all other materials are the responsibility of the exhibitor);
- (4) a brief synopsis of the subject to be exhibited.

\* \* \*

# International Surgery Meeting To Be Held in Jackson

Jackson, MS — Six hundred surgeons from five continents will meet in Jackson February 8-12 — in part because 1994 marks the 30th anniversary of the world's first heart transplant in man — performed in Jackson at the University of Mississippi Medical Center (UMC).

The Department of Surgery at UMC is host for the international meeting which convenes only once every three years and has only met twice before in the United States.

Surgery department chair Dr. Robert S. Rhodes and former chair Dr. James Hardy are both past-presidents of the Society of University Surgeons (SUS), the parent group of the combined meeting.

It was Dr. Hardy, chairman for 1955-1987, who led the surgical team which made history by transplanting the heart of a chimpanzee into the chest of a dying man on January 23, 1964. One year earlier, the same team had transplanted a human lung — also the world's first. The operations set the stage for all future heart and lung transplants — demonstrating that a transplanted lung would breathe and a transplanted heart would beat and support the blood pressure in a human host.

"Dr. Hardy was among the first SUS presidents to advocate international surgical research meetings in his presidential address in 1962," Dr. Rhodes said. Membership is limited to surgery faculty at US and Canadian medical schools who have outstanding academic credentials.

The other groups meeting with the SUS are counterparts to SUS in other countries. They are the Surgical Research Society of Great Britain, the European Society for Surgical Research, the Surgical Research Society of Australasia, the Surgical Research Society of South Africa and the Japan Surgical Society.

# Total Abdominal Colectomy For Control Of Massive Lower Gastrointestinal Bleeding

Richard J. Field, Sr, MD, FACS Richard J. Field, Jr, MD, FACS Stacy Shackleford, BS

otal abdominal colectomy is currently recommended by many authors for cases of massive lower gastrointestinal bleeding when the source of bleeding cannot be localized. 1,2,8,11,17 Recent advances in the ability to localize bleeding through a combination of fiber-optic endoscopy, selective mesenteric arteriography, and radioisotope scanners have led most authors to recommend an aggressive diagnostic workup aimed at performing a limited colonic resection. 2.4,7,8,12,16 Although the usefulness of segmental resection is wellreported, there are still many instances in which total abdominal colectomy is the only alternative. These include hemodynamic instability not allowing preoperative evaluation, previous admission for lower gastrointestinal bleeding, more than one site visualized as bleeding, good-risk patients with widespread diverticulosis, inability to localize a bleeding site, and unavailability of diagnostic procedures. 1.17 While recent authors have

From 1957-1990 four patients underwent total abdominal colectomy with primary ileoproctostomy for control of massive lower gastrointestinal hemorrhage at Field Memorial Community Hospital in the rural community of Centreville, Mississippi. Surgery was performed emergently in two cases, and urgent/electively in the two remaining cases. Bleeding was controlled in each case. Upper Gastrointestinal and rectal bleeding were excluded, but further attempts to localize bleeding were not performed due to the difficulty of obtaining these studies at our hospital and the questionable likelihood of localizing the bleeding site. Many authors recommend an aggressive diagnostic workup including radio-labeled RBC scintigraphy and mesenteric angiography to localize colonic bleeding. Their aim is to perform a directed colonic resection for control of bleeding. However, most authors support total abdominal colectomy in cases where 1) hemodynamic instability does not allow extensive preoperative evaluation 2) there is a recurrent bleeding 3) more than one site is visualized as bleeding 4) there is widespread diverticulosis in a good-risk patient or 5) diagnostic procedures are unavailable. The low morbidity and good bowel function achieved following total abdominal colectomy, combined with the unavailability of diagnostic radiographic studies leads us to recommend total abdominal colectomy for control of massive lower gastrointestinal bleeding. The mortality of the procedure can be minimized by operating in a timely manner, prior to 10 units transfusion or 4 units within 24 hours, or operating in cases of recurrent bleeding.

reported a high morbidity and mortality following total colectomy. A.15.16 others have helped to identify factors which may allow the operation to be performed more safely. These include operating prior to 10 units transfusion or when transfusion requirements exceed 4 units within 24 hours. Also, consideration may be given to elective resection for cases of rebleeding. 1.9

### Materials and Methods

From 1975-1990, four patients underwent total abdominal colectomy with primary ileoproctostomy for control of massive lower gastrointestinal bleeding at Field Memorial Community Hospital in the rural community of Centreville, Mississippi. The records of these patients were reviewed retrospectively. Total blood loss ranged from 4 to 13 units, with a mean of 6 units. Patients' ages ranged from 62-71, with a mean age of 67. There were three men and one women.

In each patient, upper gastrointestinal bleeding was excluded on the basis of a bile stained nasogastric aspirate or a normal upper gastrointestinal endoscopic exam. Barium enema was performed in all patients who did not have previously documented colonic diverticulosis. Further preoperative attempts to localize bleeding were not performed since Technetium 99m scanning was not available at that time and mesenteric angiography is not available at this hospital. The closest facilities available for these studies requires a one hour ambulance ride.

### Results

Two of the patients underwent emergency surgery on the first hospital day after a four unit transfusion requirement. One patient underwent urgent surgery on the third hospital day when transfusion requirements increased from 2 to 4 units per 24 hours with difficulty maintaining blood pressure. The fourth patient underwent elective resection following cessation of bleeding in a recurrent bleed. Bleeding was controlled without recurrent in each case. A four unit transfusion requirement in 24 hours in a patient with good operative risk and no evidence of upper gastrointestinal or rectal bleeding was considered indication for emergent surgery. The first three cases were performed with no bowel prep. The fourth case was performed electively after the bleeding was controlled due to the high risk of a third hemorrhage in a patient who has already had two episodes of bleeding. According to McGuire et al, the risk of the first rebleed is 22% while the risk of a third hemorrhage following one rebleed is 50%.

All four patients undergoing total abdominal colectomy followed a fairly smooth post-operative course. Post-operative complications did develop in both of the emergent cases The first patient developed atrial fibrillation which was refractory to medical treatment and DC cardioversion. The second patient developed a minor wound infection requiring the skin to be opened. No serious life-threatening complications occurred.

The pathology report in all four cases showed extensive colonic diverticulosis with no identification of the specific bleeding site. The second patient was additionally noted to have a superficial ulceration at the ileo-cecal junction.

No cases of disabling post-operative diarrhea occurred. Stools

TO 14	T 0		
Patient	Information	-	continued at right

Patlent Age/Sex	Blood Loss (Unlts)	Associated Medical Problems	Timing of Operation	Post-op Complications
1) 70/male	4	Htn with hyper- tensive CVD	Emergent HD#1	Atrial fibrillation
2) 62/male	4	none	Emergent HD#1	wound infection
3) 66/male	13	none	Urgent HD#3	none
4) 71/female	4	Prior lower GI bleeding	Elective HD#6	none

per day at discharge ranged from 2-3 day in the fourth patient to 4-6 day in the third patient. Three patients required Lomotil for control of diarrhea initially, and two were subsequently able to discontinue it. All four patients reported 1-2 stools/day one month post-operatively with one patient continuing on anti-diarrheal medication.

### Discussion

Total abdominal colectomy for the management of uncontrolled colonic hemorrhage was first reported by Cate in 1953.3 He described a 40 year old female who had multiple bleeding episodes with cecal and colonic diverticula. She underwent negative laparotomy with failure to identify a bleeding source. Due to continued bleed with massive transfusion requirements and failure to isolate a bleeding point, she underwent sub-total abdominal colectomy. According to Dr. Cates, "The treatment was radical. It appears in this case that it was lifesaving."

Encouraged by this single case report, total abdominal colectomy became an acceptable alternative for management of uncontrollable lower gastrointestinal bleeding over the next two decades. 9,17 The procedure reached a height of popularity following a 1973 report by Drapanas et al<sup>5</sup> which showed a markedly decreased mortality compared to more limited resections.

More recent reports4,14,15 have shown a much higher mortality rate for total abdominal colectomy than the enthusiastic earlier report by Drapanas et al, ranging from 25-33% mortality vs. 11% by Drapanas. A cumulative mortality of 22.6% for all series from 1972-1990 was also reported.1 The reason for this difference is unclear, but may be related to the timing of operation in relation to the amount of hemorrhage. Drapanas et al reported a mean transfusion requirement of 5 units for patients undergoing total abdominal colectomy, and a minimum of only 2 units. A recent report cited 65% of cases receiving greater than 10 units of blood.1 These greater transfusion requirements were associated with a 45% mortality compared to a 7.7% mortality in the remaining patients who received less than 10 units.1 However, since bleeding will often abate spontaneously, it is important not to operate prematurely.<sup>4,9</sup> Authors have described a requirement of 4-5 units of blood in 24 hours as the cutoff for an aggressive surgical approach.<sup>7,9,11,15</sup> Based on our experience, we favor early operative intervention for patients bleeding briskly as evidenced by a 4 unit transfusion requirement in the first 24 hours.

Recent improvements in the ability to localize lower gastrointestinal bleeding have led most authors to favor limited colonic resection. Two studies8,12 reported a 94% and 100% success rate for localizing bleeding in patients requiring emergency surgery using in vitro Technetium 99m-labeled RBC scintigraphy. These scans allowed surgeons to perform directed colectomies with no episodes of rebleeding in 25 patients undergoing surgery and 2 post-operative deaths (8% mortality). Additionally, since the scan was positive in only 2 of 50 patients who did not require surgery, but localized bleeding in 15 to 16 patients requiring surgery, Orecchia et al advocated the use of scintigraphy to help identify those patients requiring surgery.

Success in localizing bleeding

### Patient Information - continued

Stools/day at Discharge	Stools/day at 1 month post-op	Pathology	Rebleeds	Follow-up Length
4-5	2	Diverticulosis	none	3 1/2 years
4-5	2	Diverticulosis superfi- cial ulceration ileo- cecal junction	none	5 years
4-6	2	Diverticulosis	none	3 years
2-3	1-2	Diverticulosis	none	5 years

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has also been achieved by selective mesenteric arteriography. Although a higher bleeding rate of 0.5 to 1.0 mL/min (vs. 0.12 to 0.5 mL/min for scintigraphy) is required for detection of bleeding, along with active bleeding at the time of injection, successful localization of bleeding was reported in 42-50% of cases. 4.16

Most recent authors have recommended an aggressive diagnostic workup for localization of bleeding to include nasogastric aspiration and sigmoidoscopy initially, followed by colonoscopy, scintigraphy, and angiography.2.4 A directed resection is favored due to decreased morbidity and mortalitv. 2.4.7.8.12.16 Total abdominal colectomy is still the procedure of choice for cases where bleeding cannot be localized with the above procedures. 1,2,8,11,17

From the perspective of a small rural hospital where scintigraphy and angiography are not available without transporting the patient to another facility, the truly emergent cases may have to be performed without the benefit of localization of bleeding. In our experience with four cases, we have found "blind" total abdominal colectomy to be effective in controlling massive lower gastrointestinal hemorrhage with low morbidity and no mortality. Additionally, it is reasonable to believe that those patients who are stable enough to undergo transport in order to obtain scintigraphy or angiography will have a low likelihood of having a localizing scan or to ultimately require surgery.

Render et al stated that the reluctance of most surgeons to operate until absolutely necessary may contribute to the mortality of total abdominal colectomy. This led to the recommendation to perform total abdominal colectomy on an elective/urgent basis for patients with recurrent bleeds, while operating on emergent cases prior to 10 units of transfusion. Mortality can be decreased by proceeding immediately with operation on a rebleeding episode or on initial presentation if bleeding is especially profuse. Bender et al also stated that if the 10 unit limit is passed, strong consideration should be given to ileostomy to reduce the high mortality associated with anastomotic leak in these patients.

### Conclusion

Total abdominal colectomy can be safe and effective means of controlling massive lower gastrointestinal bleeding if used in a timely manner, i.e., prior to 10 units transfusion of after 4 units transfusion in 24 hours. From the standpoint of a small rural hospital, we consider this the procedure of choice after gastrointestinal and rectal bleeding have been ruled out. The low morbidity and resulting good bowel function make this an acceptable procedure given the difficulty of obtaining extensive diagnostic studies which have a questionable likelihood of demonstrating a bleeding site.

Field Clinic PO Box 339 Centreville, MS 39631-0339

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ence to Angiodysplasia and Diverticular Disease. World J of Surg 1978;2:73-80.

Dr. Field, Sr. is a surgeon in private practice in Centreville, Mississippi. He is also Clinical Professor of Surgery, Tulane University School of Medicine, New Orleans, Louisiana; Louisiana State University School of Medicine, Baton Rouge, Louisiana; University of Mississippi School of Medicine, Jackson, Mississippi. Dr. Field, Jr. is a surgeon in private practice in Centreville and an Instructor of Surgery, Tulane University School of Medicine, New Orleans, LA. Ms. Shackelford is a senior medical student, Tulane University School of Medicine, New Orleans, LA.

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FEBRUARY 1994 33

# **Information For Authors**

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) The original and one duplicate should be submitted. The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one-to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

**Key Words** should follow the abstract and be identified as such. Provide three to five key words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

### **Journals**

[1] Author(s). Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] Title of article. Capitalize only the first letter of the first word. [3] Name of Journal followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] Year of publication; [5] Volume number: Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] Inclusive page numbers. Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

### **Books**

[1] Author(s). Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] Title, Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] Edition number, [4] Editor's name. [5] Place of publication, [6] Publisher, [7] Year, [8] Inclusive page numbers. Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

Illustrations should be submitted in duplicate in an envelope (paper clips should not be used on illustrations since the indentation they make may show on reproduction). Legends should be typed, doublespaced on a separate sheet of paper. Photographic material should be high-contrast glossy prints. Patients must be unrecognizable in photographs unless specific written consent has been obtained, in which case a copy of the authorization should accompany the manuscript. All illustrations should be referred to in the body of the text. Omit illustrations which do not increase understanding of text. Illustrations must be limited to a reasonable number (four illustrations should be adequate for a manuscript of 4 to 5 typed pages.) The following information should be typed on a label and affixed to the back of each illustration: figure number, title of manuscript, name of senior author, and arrow indicating top.

**Tables** should be self-explanatory and should supplement, not duplicate, the text. Each should be typed on a separate sheet of paper, be numbered, and have a brief descriptive title.

Acknowledgments are the author's prerogative; however, acknowledgment of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

Galley Proofs will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs. □

# Mississippi State Board Of Medical Licensure Annual Report

July 1, 1992 through June 30, 1993

Frank J. Morgan, Jr., MD Executive Officer

The Mississippi State Board of Medical Licensure is the State's legally constituted licensure Board for physicians (M.D.), osteopathic physicians (D.O.), and podiatrists (D.P.M.). The Board, which meets bimonthly on the third Thursday beginning in January of each year, is composed of nine physicians appointed to staggered terms by the Governor.

The Board is responsible for setting policies and professional standards concerning the practice of physicians (M.D.), osteopathic physicians (D.O.), and podiatrists (D.P.M.); considering applications for licensure; conducting examinations for licensure; investigating legitimate drug traffic among medical practitioners under the Uniform Controlled Substances Act; conducting investigations in disciplinary matters involving violations of state and federal laws; probation, suspension and revocation of licenses; considering petitions for terminations of probationary and suspension periods and restoration of revoked licenses; promulgating reasonable rules and regulations necessary to enable it to discharge its functions; and enforcing the provisions of the law regulating the practice of medicine.

The administrative functions of the Board are performed under the direction of its Executive Officer, Frank J. Morgan, Jr., M.D., by eleven full-time staff members, including five investigators; an administrative assistant; a licensing officer; an accountant, and two secretaries. The office of the Board is located at 2688-D Insurance Center Drive, Jackson, Mississippi 39216.

### Licensure

Any physician, osteopathic physician, or podiatrist desiring to practice medicine in Mississippi must first obtain a license to do so by contacting the Board. When an inquiry concerning licensure is received, a questionnaire to elicit certain pertinent information is sent to the practitioner. Based upon the information given by the practitioner, a determination is made as to his/her eligibility for licensure.

Names of references submitted on the questionnaire, as well as the American Medical, Osteopathic, or Podiatric Medical Associations; other states in which the practitioner has been licensed; and hospitals where the practitioner has held staff privileges are sent inquiries. If the information received is favorable, an application is sent to the physician.

### Reciprocity/Endorsement

The Board of Medical Licensure may grant licenses to practice medicine without examination as to learning, to graduates in medicine, osteopathic medicine, or podiatry who hold licenses to practice from other states, provided the requirements in such states are equal to those set forth by the Mississippi Board. In addition, this Board may affiliate with and recognize for the purpose of waiving examination, diplomates of the National Board of Medical Examiners, the National Board of Osteopathic Medical Examiners and the National Board of Podiatry Examiners in granting licenses to practice in Mississippi.

During FY93, 943 practitioners requested applications for licensure by reciprocity with other states or through endorsement of the examinations given by the National Board of Medical, Osteopathic, and Podiatric Examiners. Based upon these requests, 331 applications were processed and approximately 12,260 reference inquiries were made by the Office of Medical Licensure to determine the eligibility of applicants for a license to practice in Mississippi.

Following receipt of favorable certificates of training and personal interviews, a total of 327 physicians, 12 osteopathic physicians and 8 podiatrists were licensed in Mississippi.

In addition, 4 temporary medical licenses which allowed applicants 30 days in which to complete the necessary requirements for permanent licensure were issued.

Effective July 1, 1982, an amendment to the Medical Practice Act permitted the issuance of temporary licenses to non-resident and retired resident physicians to practice for up to 90 days in *licensed youth camps* in Mississippi. Six (6) such licenses were issued during FY93.

### Examination

The nationally administered Federation Licensing Examination (FLEX) was adopted as the state's medical licensing examination in 1973. The three-day FLEX is a written objective-type, comprehensive examination which tests applicants in the basic sciences, clinical sciences, and clinical competence. Component I is designed to evaluate measurable aspects of knowledge and understanding of basic and clinical science. Component II focuses on critical abil-

ities and knowledge required for diagnosis and management of selected ambulatory and in-patient clinical problems representing a core of clinical situations frequently encountered by the physician licensed for the independent practice of medicine. A score of 75 is required on each component for passing. The FLEX is given in June and December of each year, and the dates are set by the Examination Board of the Federation of State Medical Boards of the United States, of which this Board is a member.

Applicants for licensure by examination are screened in the same way as those seeking licensure by reciprocity. References are obtained and credentials are checked thoroughly. During FY93, 109 applicants were declared eligible and took the examination. Ninety-two (92) passed both components. Those applicants who were successful will be granted licensure upon their submitting documentation of completion of one year of accredited postgraduate training.

Beginning in the Spring of 1988, SPEX (Special Purpose Examination) was offered as a quarterly administration: March, June, September, and December. The June and December SPEX administrations are set to coincide with the last day of the three-day FLEX administration.

This one-day examination is administered to applicants who possess all the qualifications for licensure by reciprocity/endorsement, with the exception of having successfully passed a written medical competency examination within a 10 year period prior to filing his/her application.

In FY93, 8 candidates made application and took SPEX. Four failed and four passed.

A total of 53 restricted temporary licenses were issued for the period July 1, 1992 through June

30, 1993, to applicants for licensure who entered their first year of postgraduate training at the University of Mississippi Medical Center, Jackson. The temporary licenses permitted them to practice only within the scope of their respective residency training programs at the University.

### Limited Institutional Licensure

In addition to licensure by examination and reciprocity, state law also provides for limited institutional licensure which is available only to graduates of foreign medical schools for their employment in state-supported institutions. It was the intent of the law to enable Mississippi institutions to utilize the services of qualified foreign medical graduates during the period necessary for them to meet the requirements for permanent licensure.

Based upon their presenting to the Office of Medical Licensure their original medical diplomas, documentation of certificates from the Educational Commission for Foreign Medical Graduates (ECFMG), Visa Qualifying Examination (VQE), or Foreign Medical Graduate Examination in the Medical Sciences (EMGEMS), and favorable references, 11 applicants were issued limited institutional licenses to practice in state-supported institutions. In addition, 21 limited institutional licenses were renewed during this period.

Since limited institutional licensure was established in 1971, 383 such licenses have been issued. As of June 30, 1993, a total of 2 of the limited institutional licensees have met all requirements, including passing the FLEX and fulfilling the postgraduate training requirements, and have been issued permanent medical licenses in Mississippi.

### Certification And Verification

A practitioner originally licensed in Mississippi by examination who seeks licensure in another state through reciprocity must have his license in this State and the scores he obtained on the licensure examination certified by this Board to the reciprocating state. 461 such certifications were made by the office of Medical Licensure during FY93 and 99 letters of good standing were completed.

The Board also verified the licensure status of practitioners to health care providers, health insurance carriers, licensing boards of other states, and state and federal law enforcement and regulatory agencies. Approximately **7,894** verifications of licensure were made by this Board during FY93.

### **Annual Renewal**

The license of every physician, osteopathic physician, and podiatrist licensed to practice in the state must be renewed annually. On or before May 1, of each year, an application for renewal of license is mailed to all practitioners licensed by this Board to practice in Mississippi. The application must be completed and returned to the Board along with the renewal fee by June 30.

Based upon information given on the renewal applications, as of July 1, 1992, there were 6,233 physicians licensed to practice medicine in Mississippi. Of this number 3,828 resided and practiced in state and 2,405 resided out of state.

A total of 1,819 in-state physicians worked in the primary care specialties, which include family practice, 554; general practice, 216; internal medicine, 508; pediatrics, 265; and obstetrics and gynecology, 276.

As of July 1, 1993, 6,466 practitioners had renewed for the pe-

riod July 1, 1993 through June 30, 1994. 4,003 practice and reside in Mississippi and 2,463 reside out of state, but elected to maintain current licensure in Mississippi.

### Investigations

Under the direction of the Executive Officer, the Board's five investigators carried out the responsibilities of investigating alleged violations of the Medical Practice Act and the Mississippi Uniform Controlled Substances Act as it applies to medical practitioners. During the fiscal year the Board received 176 complaints regarding alleged violations from various sources including state and federal law enforcement officials, state and federal regulatory agencies, hospital administrators, local and state medical societies, medical licensing boards of other states, health professionals, and lay individuals. A total of 228 practitioners or individuals were investigated by the Medical Board investigative staff. In conducting these investigations and inspections a total of 779 pharmacies were profiled throughout the State of Mississippi. Analysis of the 228 investigations revealed 160 practitioners were investigated for suspicious or excessive prescribing of controlled substances; 24 involved failing to keep records of substances dispensed/prescribed; 4 involved personal use of or addiction to drugs; 1 involved mental illness; 35 investigations involved unprofessional conduct; 3 involved the illegal practice of medicine; 1 involved sexual abuse of patients; Of the 160 investigations involving suspicious or excessive prescribing patterns; 47 of these practitioners were written letters by the Executive Officer warning them against future violation of federal and state laws regarding prescribing of controlled substances. Additionally, 92 urine screens were collected and 84 compliance inspections/audits of drugs handled by dispensing physicians were accomplished.

As a result of the investigations 6 practitioners had their privileges (DEA Certificate) authorizing them to handle controlled substances restricted. One (1) of these investigations involved a physician who was personally abusing controlled substances; four (4) involved excessive prescribing and one (1) involved unprofessional conduct.

### **Disciplinary Actions**

Additionally, investigations conducted by the Board resulted in 4 disciplinary hearings. Following consideration of these matters, 1 license was revoked; 1 medical license by reciprocity was denied; 2 licenses suspended; 1 suspended, suspension stayed, probation with conditions and 1 voluntary surrender of license was accepted.

Petitions for removal of restrictions were considered on 7 medical licenses. Of these, the Board denied 5 and granted 2.

Seven (7) physicians requested reinstatement of their medical licenses. Four were denied and 1 was granted; 2 were granted with conditions.

In other actions, the Board granted 2 licenses by reciprocity and denied 1. Two (2) voluntary surrender of medical licenses were accepted.

Five (5) physicians had their controlled substances prescribing privileges restored and 1 physician was denied permission to re-register with the Drug Enforcement Administration for prescribing privileges.

Entering into Consent Agreements with 15 physicians, the Board revoked 3 licenses, stayed the revocation and placed licenses on

probation; suspended 3 licenses, stayed the suspensions and placed licenses on probation; accepted 2 voluntary surrender of medical license; placed 1 license on probation and restricted 3 medical licenses. The Board gave a precautionary warning to 1 physician and placed the license of 1 physician in inactive status.

The following is the current Board membership as of June 30, 1993:

W. W. Walley, MD 804 Mississippi Drive Waynesboro, MS 39367 Term: 07/01/88 - 07/01/94

Helen B. Barnes, MD 2915 North State Street Jackson, MS 39202 Term: 07/01/92 - 07/01/94 (Fills unexpired term of Billy Wayne Long, M.D.)

John Purves McLaurin, Jr., MD 2200 South Lamar Blvd., Suite C Oxford, MS 38655 Term: 01/25/90 - 07/01/94

John Langan Pendergrass, MD P. O. Box 15729 Hattiesburg, MS 39404 Term: 07/01/90 - 07/01/96

Walter Henry Rose, MD, President 122 East Baker Street Indianola, MS 38751 Term: 07/01/90 - 07/01/96

Edwin G. Egger, MD 505 Arnold Avenue Greenville, MS 38701 Term: 07/01/92 - 07/01/98

Thomas Steve Parvin, MD, Vice President 105 Doctors Park Starkville, MS 39759 Term: 07/01/88 - 07/01/98

Richard Franklin Riley, MD, Secretary 1805 36th Street Meridian, MS 39305 Term: 07/01 /88 - 07/01 /98

VACANT - Resignation of Joseph R. Mitchell, M.D. Gulfport, MS - 06/30/93

### SUMMARY FY93 Statistics (July 1, 1992-June 30, 1993) Mississippi State Board of Medical Licensure

### LICENSURE:

<b>Permanent Licenses Issued</b>	340
Temporary Licenses Issued	56
Limited Institutional Licenses Issued	14
Licenses Certified to Other States	560
Verifications	7,894
<b>Applicants Taking FLEX</b>	109
<b>Applicants Taking SPEX</b>	8
Total Licenses Renewed (July 1, 1992)	6,233

### End of Current Renewal Period (June 30, 1993)

	In-State	Out-of-State	Total
No. of MD's	3,849	2,397	6.246
No. of DO's	113	37	150
No. of D.P.M's	41	29	70



The President's Page DON Q. MITCHELL, MD

# The Spirit Of Love

You will find as you look back upon your life that the moments when you have really lived are the moments when you have done things in the spirit of love.

Harry Drummond

Pebruary 14th is Valentine's Day. Valentine's Day is synonymous with love and as I think about the things I love - my wife, children, family, church, country - there is a new addition this year — the MSMA Alliance. I have always understood that our Alliance had projects, but until I became president of this association, I never appreciated the depth of their commitment in the spirit of love.

For example, Health Choice '94 will touch 6000 children's lives in Hattiesburg, Columbus and Jackson this year. This project, which started 4 years ago in Hattiesburg with approximately 100 children participating, has now spread over the state. Our Alliance members have nurtured and expanded this program in an effort to improve not only the health of these children but also their self-esteem.

A second example is the Central Medical Alliance's Blake Clinic Project. As many of you know, the Blake Clinic staff provides medical assistance to children with physical handicaps and special health care needs. Central Medical Alliance members solicited donations of office furniture, carpet, artwork, and landscaping from local businesses and individuals to improve the Clinic's physical appearance. Through their volunteer efforts a more pleasant environment has been provided for these children and their families who spend numerous hours in the clinic.

A third example is the Domestic Abuse Shelter in Hattiesburg, sponsored by the South Mississippi Medical Alliance. This project received the 1993 AMA Health Awareness Promotion Award presented by the AMA Alliance. Alliance members spent more than a year finding a suitable location, funding and furnishing the domestic abuse shel-

(Continued on page 42)

# **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 2 FEBRUARY 1994

# Government Medicine — Canadian Style

Quite naturally the conversation at coffee rounds in the physician's lounge the morning following the President's State of the Union address was centered on health care politics.

During this discussion the subject of a Canadian Based Health Care System came up. At that point one of the physicians present related a recent conversation he had had with a friend, a family physician, in Ontario.

He related that Ontario physicians on contract with the government faced having their monthly checks withheld because the health system was running out of money for the fiscal year, and would be in a position of covering emergencies only.

The initial steps taken by the government to address this financial problem are:

- 1. Starting in March, each physician will have to take off one week each month. If they want to work that week, they will not receive any compensation for their work or to cover their overhead cost.
- 2. The five percent provider tax will apply to all billing... not collections and the tax will not be deductible from personal income taxes.

In response the Ontario Medical Society proposed that all physicians become civil servants, on a salary with government furnishing all services necessary to support the physician as well as making physicians eligible for civil service retirement benefits. Of course all of these were depied.

After further questioning, I was given a telephone number of the Ontario Medical Society and instructed to call it for further information. Upon doing so, I recorded the following message:

The government has refused to accept the OMA Council's proposal of mandatory social contract days, capping payments to individual doctors. The OMA proposal attempted to meet government expenditure reduction targets under the social contract in the fairest and least disruptive way possible for Ontario patients.

The 4.8% hold back which commenced on October 1 will continue for the remainder of the fiscal year. However, based on preliminary expenditure projections it will not be sufficient to meet the Government's expenditure targets for the 1993-94 year. This means that theoretically funds for medical services will run out sometime in March. Payments for services provided by physicians after that point will eventually be taken back by government (emphasis mine).

The OMS will be launching a comprehensive communications plan advising physicians on how to deal with the impact of government cutbacks on office management and delivery of care. In the weeks ahead, the Association will also mount a comprehensive public education campaign to focus responsibility on government for imposing expenditure reduction targets.

In Canada there is no "Universal National Health

(Continued on page 42)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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ter. They raised \$30,000 with donations from local organizations, the medical society, various fund-raising efforts and physicians. This is an ongoing project. The alliance continues to support the Shelter's many needs... truly efforts made in the spirit of love. This project was featured in the December 1993 issue of the AMA Alliance's *Facets* magazine.

There are many other projects supported by our Alliances including gifts to the Mississippi Firefighter Memorial Burn Center in Greenville by the Washington County Alliance, HIV education for students provided by the Singing River Alliance members, the Lee County Alliance member's child immunization project, and the list just goes on and on.

And truly in the spirit of love, our MSMA Alliance has not neglected their own. They have provided marvelous ongoing financial support for medical education. At the Annual Session last year in Biloxi, the Alliance presented checks in the amount of \$25,702.31 to our medical school. Their goal for this year is even greater.

Approximately 20 of our Alliance members participate in a weekly conference call during the legislative session. Alliance members are currently participating in a phone bank as well as grassroots lobbying efforts for passage of MSMA supported legislation. They served boxed lunches to 225 legislators during our January 18th Socioeconomic and Legislative Forum.

For all this and so much more, I pause to say thank you to the MSMA Alliance members for all of these special moments given "In The Spirit of Love".

Your colleague,



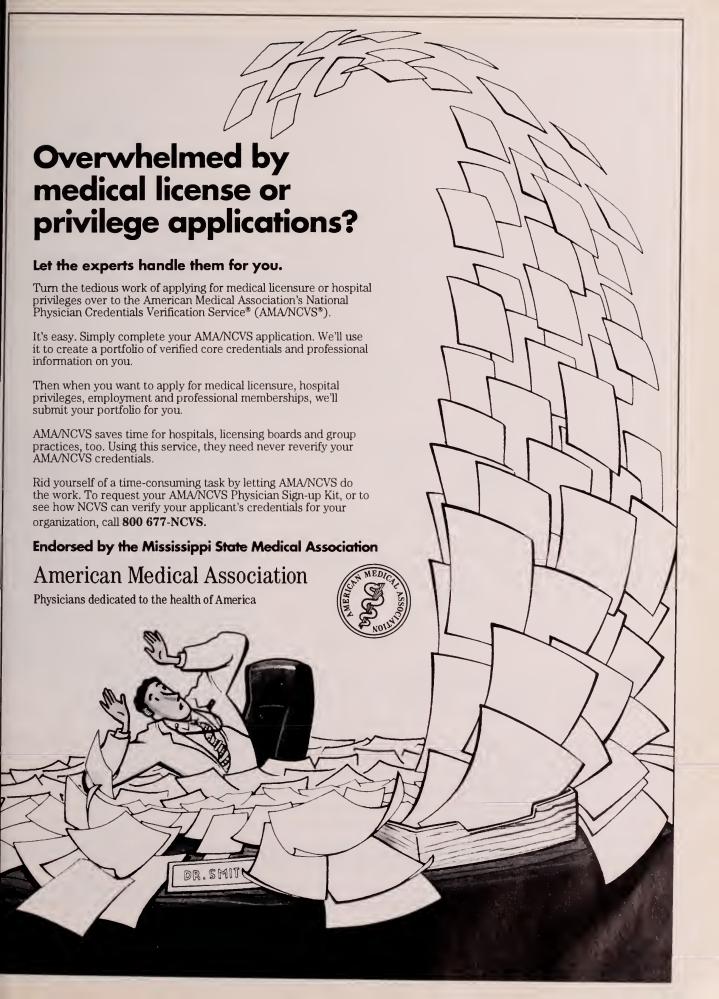
Care System", rather each province has its own medical system. This is what the current administration in this country is proposing, a group of Alliances to which membership would be mandatory. Although we will all be taxed the same, no matter which Alliance we are a member of, we will not all receive the same care, as the care rendered will be determined by each Alliance.

This concept is foreign to our form of government but one can easily envision the above scenario occurring in this country in the near future if such a plan is adopted.

One of the most important decisions any citizen in this country has to make during a lifetime is health care coverage. It is indeed unfortunate that the public cannot get direct and unbiased information from our public officials, the insurance industry or the media so that an informed decision can be made. Only when the above quoted actions occur in this country will they realize what has happened to them.

Myron W. Lockey, MD Editor





# **Medical Organization**

### Dr. C. G. Sutherland

Dr. Clarence Garland ("Tanny") Sutherland, 72, died January 1 at Mississippi Baptist Medical Center in Jackson.

Dr. Sutherland served as Medical Director of the Medical Assurance Company of Mississippi (MACM) from May 1980 until June 1993. From 1997-1979 he served on various committees within MACM while he was in the private practice of obstetrics and gynecology at the Jackson Woman's Clinic.

A native of Canton, he was educated in public schools and graduated in 1939 as salutatorian of his class. He received his B.S. degree at Mississippi State University and his M.D. degree at Vanderbilt School of Medicine, Nashville, TN. He had his intership and assistant resident training at Vanderbuilt.

Dr. Sutherland took his residency training in obstetrics and gynecology at the University of Arkansas School of Medicine at Little Rock. While at Arkansas, he also served as assistant professor and assistant dean of the Arkansas School of Medicine.

Dr. Sutherland was a Fellow of the American College of Obstetrics and Gynecology, certified by the American Board of Obstetrics and Gynecology and a Fellow of the American College of Surgeons. He was a member of the Central Medical Society, the Mississippi State Medical Association, the American Medical Association, and the Mississippi Section of the American College of Obstetrics and Gynecology.

He was former President of the Central Medical Society. He was a former Vice President, Secretary-Treasurer, and member of the Board of Trustees of the Mississippi State Medical Association. He was also a member of the CHAMPUS review committee for the Association. He was a member of the Mississippi State Board of Nursing Home Administration, Vice-Chairman of the Mississippi Section of the American College of Obstricians and Gynecologists and a member of the State Board of Nurses' Examiners.

Dr. Sutherland was a staff member of Mississippi Baptist Medical Center, St. Dominic-Jackson Memorial Hospital and Hinds General Hospital; now Methodist Medical Center. He was for many years a consultant of the Mississippi State Hospital at Whitfield and on the teaching-visitors staff at the University Medical Center.

Dr. Sutherland was a member of St. Luke's United Methodist Church.

# **Executive Officer Appointed For Licensure Board**

T. Steve Parvin, MD, President of the Mississippi State Board of Medical Licensure and a general surgeon who practices in Starkville, announced the appointment of P. Doyle Bradshaw to the position of Executive Officer of the Board, which was vacated by the retirement of Frank J. Morgan, Jr., MD, December 31, 1993. The appointment, made at the December 16

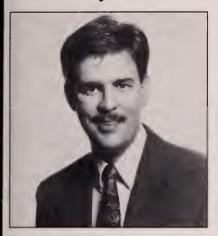
meeting of the Board, became effective January 1, 1994.

Mr. Bradshaw, a native of Mississippi, resides in Jackson and has been associated with the State Department of Health since 1972 when he began working in the Division of Emergency Medical Services. He later held the position of Administrator, West Central Public Health District V, and since January, 1987,

has been the Director, Division of Disease Control, Bureau of Preventive Health Services, Mississippi State Department of Health.

Dr. Parvin stated, "Doyle Bradshaw is well qualified to assume the position of administrator for Mississippi's very active Medical Licensure Board." A physician medical consultant will be named to work with the Board.

# AMA Recognizes Dr. Thaggard For Community Service



Anson L. Thaggard, MD

University of Mississippi Medical Center resident, Anson L. Thaggard, MD, and his contributions to community service were recognized recently by the American Medical Association (AMA). Dr. Thaggard was one of 50 honorees of the AMA/Burroughs Wellcome Co. Leadership Award Program for resident physicians.

The AMA established the Leadership Program in 1988 with a grant from pharmaceutical manufacturer Burroughs Wellcome Company. Awardees from across the U. S. attended the AMA Resident Physicians Section Interim Meeting held December 3-4, 1993 in New Orleans, Louisiana. The awardees will have the opportunity to attend the Annual Meeting in Chicago in June. The Leader-

ship Program is designed to build ties between organized medicine and resident physicians who have displayed a commitment to community service.

Dr. Thaggard volunteers at a community clinic where he provides care for indigent patients on a walk-in basis. Dr. Thaggard works with elementary students by providing them with sports physicals and speaking to them about the importance of education and pursuing one's goals. Finally, he ministers both physically and spiritually through the hospital ministry of his church.

The AMA/Burroughs Wellcome Co. Leadership Award Program will continue in 1994 and will honor 50 residents nationwide.



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# Medical Staff Officers Elected At St. Dominics



Henry B. Tyler, MD

The medical staff of St. Dominic-Jackson Memorial Hospital recently elected officers to serve for the coming year. Henry B. Tyler, MD was elevated from Chief-elect to Chief of Medical Staff. William A. Causey, MD, will serve as Past Chief of Staff and Jeff A. Fletcher, MD, as Secretary/Treasurer.

William F. Krooss, Il, MD, was named to serve as new Chairman of the Department of Family Practice. Three other physicians will continue serving their unexpired terms as Chairman. They are George E. Patton, MD, Department of Medicine; William C. Welch, Jr., MD, Department of Psychiatry; and W. Maret Maxwell, MD, Department of Surgery.

New Service Chiefs are: Alan R. Peeples, MD, Anesthesiology; George K. McMullan, Jr., MD, Cardiology/Cardiovascular Surgery; Daniel Quon, DMD, ENT/Oral Surgery; A. Michael Koury, MD, General Surgery; E. E. Robinson, III, MD, Neurology/Neurosurgery; Sidney A. Johnson, MD, Oncology; Donald C. Faucett, MD, Ophthalmology; Geraldine B. Chaney, MD, Pediatrics; Phillip K. Blevins, MD, Plastic Surgery; John E. Mdridge, MD, Urology; and James M. Jucker, MD, Gynecology.

Dr Tyler is a founder of the

cardiovascular program at St. Dominic's. He performed the first cardiovascular surgery procedure at St. Dominic's in 1974. He has also served as both Chief and Director of Cardiovascular Surgery.

Dr. Tyler attended Vanderbilt University where he received his B. A. degree. He received his M.D. degree from Johns Hopkins Medical School, where he was President of the Pithotomy Club (medical-social fraternity). He served residencies at both Peter Bent Brigham Hospital and the Children's Hospital Medical Center (Harvard Medical School), Boston, Massachusetts.

He holds board certification from the American Board of Surgery and the American Board of Thoracic Surgery. He is a member of the MS State and American Medical Associations; Past President of the MS Surgical Association; Past President and a founder of the Jackson Surgical Society; Central Medical Society; Past President of the American College of Surgeons/ Mississippi Chapter; Past President of the American Heart Association, Mississippi Chapter; and currently serves as a Governor of the American College of Surgeons for Mississippi. He is on the boards of St. Dominic Hospital, Annandale, and University Club. He is a member of the board and Past President of River Hills Club.

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Clare Hester, Director of Legislative Activities, MSMA

# MSMA/MHA 1994 Joint Legislative Forum & Reception Held January 18 in Jackson

The 1994 MSMA/MHA Legislative Forum and Reception, held January 18 in Jackson, brought in a record number of physicians, MSMA Alliance members, and hospital executives from around the state. Over 700 attendees gathered at the Ramada Coliseum to learn more about current legislation affecting areas of health care in Mississippi.

During the MSMA House of Delegates meeting members heard both an update on the Mississippi Physicians Care Network and a report from Dr. John Simmons on the current status of South Carolina's program.

Attendees were also able to participate in panel discussion led by key health care executives, physicians and businessmen. To discuss the national perspective on health reform, US Senator Thad Cochran joined John B. Crosby, JD, senior vice president for health policy development and advocacy of the American Medical Association; and W. Briggs Hopson, MD, chairman of the Governor's Task Force on Health Reform.

Panel members discussing the

impact of health reform on Mississippi included: J. Edward Hill, MD, representing physicians in rural settings; Thomas C. Fenter, MD, representing physicians, in urban settings; and Jere Hess, director of personnel and public relations for Peavey Electronic Corporation based in Meridian, representing the business community.

During the Luncheon, motivational speaker Tom Sullivan, author of If You Could See What I Hear, presented *Pride in People with Purpose and Passion*. Sullivan has overcome his blindness with incredible success. His combination of heart wrenching testimony and uplifting songs brought an extended round of applause from the audience.

Following the luncheon, Dr. Authur C. Guyton presented Medical Writing Awards, sponsored by the Mississippi Writers Association, to Dr. Terry M. Dwyer, associate professor of physiology and biophysics, UMC and Dr. Carol E. H. Scott-Conner, MD, professor of surgery, UMC.



John W. Simmons, MD, Senior Vice President for Medical Staff Affairs, Spartanburg, South Carolina



Carol Scott-Conner, MD, Recipent, Medical Writing Award, MS Writers Association



W. Briggs Hopson, MD, Chair, Governor's Task Force on Health Reform



Senator Thad Cochran



Tom Sullivan, Luncheon Speaker



Terry M. Dwyer, MD, Recipent, Medical Writing Award, MS Writers Association



John B. Crosby, J.D., Senior Vice President for Health Policy Development and Advocacy, AMA

# The University of Mississippi Medical Center

# Merideth AMA/Glaxo Achievement Award Recipient



Dr. Phillip Merideth, a University of Mississippi Medical Center psychiatry resident, has been selected to receive the American Medical Association/Glaxo Achievement Award.

Chosen for his outstanding leadership, Dr. Merideth will attend the 1994 AMA Leadership Conference in San Francisco.

"I was very honored to be among the group of 25 physicians selected nationwide. I am pleased to participate in this AMA program, Dr. Merideth said.

A native of Greenville, Dr. Merideth holds degrees in law and medicine from the University of Mississippi.

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# New Children's Hospital To Be Named For Dr. Batson

The Board of Trustees, Institutions of Higher Learning, has approved the Medical Center's request to name the new children's hospital for Dr. Blair E. Batson, professor emeritus of pediatrics and first chair of the Department of Pediatrics at UMC.

The Blair E. Batson Hospital for Children will be five additional floors atop the Mississippi Children's Cancer Clinic. Construction is expected to begin in January, 1995, and an "air" breaking ceremony and dedication is planned. Preliminary plans call for a special pediatric bone marrow transplant unit, 26 inpatient rooms, with office, classroom space, waiting areas, playrooms and patient classrooms on each floor.

Chairman from 1955 when the Medical Center opened until his retirement in 1988, Dr. Batson was the prime mover in the planning and construction of the existing Children's Hospital, Completed in 1968.

"No single individual has had a more positive impact on the health of Mississippi's Children than Blair Batson," said UMC vice chancellor Dr. Norman Nelson. "Naming our new children's hospital for him is a fiting tribute to his life-long commitment."

# Survey Names Best Doctors in America

Ten UMC faculty members are among the physicians to be included in the 1994-95 edition of Best Doc-

tors in America. The directory is the result of year-long, nationwide poll of thousands of medical specialist. Physicians were asked to evaluate their peers by answering this question: "If a friend or loved one came to you with a medical problem in your field of expertise, and for some reason you could not handle the case, to whom would you send them?"

Selected for inclusion are Dr. James Achord, professor of medicine and director of digestive diseases; Dr. Richard Boronow, clinical professor of ob-gyn; Dr. James Corbett, chairman of neurology; Dr. Bryan Cowan, professor of ob-gyn and director of reproductive endocrinolgy; Dr. John Eichhorn, chairman of anesthesiology; Dr. James Hughes, chairman of orthopedic surgery; Dr. John Morrison, professor of ob-gyn; Dr. John B. O'Connell, chairman of medicine; and Dr. Tate Thigpen, professor of medicine and director of oncology.

# **Dr. Haines Named Consultant**



Dr. Duane E. Haines, professor and chairman of the Department of Anatomy at The University of Mississippi Medical Cen-

ter, will serve as the neuroanatomy consultant for the 26th Edition of Stedman's Medical Dictionary. Each edition has only one consultant in each of the various basic science and clinical science areas.  $\Box$ 





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# **Personals**

Paul M. Allen, a gynecologist and obstetrician practicing in Pascagoula, has been invited by the American College of Physician Executives to give a presentation on Risk Management Issues in the Physician's Office and Ambulatory Healthcare Center, at an interactive poster session featured in the College's upcoming 1994 Prospectives in Medical Management Conference to be held in Washington, D.C., May 7. Dr. Allen's material will also be included in a casebook the College is publishing on current issues in medical management.

**Donald W. Benefield**, of Gulfport has been elected a Fellow of the American Academy of Ophthalmology.

**Kerry L. Bernardo**, of Hattiesburg was recently named a Fellow of the American College of Surgeons.

Bertha J. Blanchard, of Hattiesburg announces the relocation of her practice in general neurology to 105 Asbury Circle, Suite C, Hattiesburg.

Luis V. Borrell, of Meridian has associated with Deborah J. Downing and the Riley Family Care, in the practice of internal medicine, 2321 13th Street, Meridian.

Thad Carter and Craig Dawkins announce their partnership in the practice of urology, Coast Urology Center, 1213 Broad Avenue, Gulfport.

Harry E. Dayton announces the relocation of his offices for the practice of internal medicine and cardiology to 1411 22nd Avenue, Meridian.

James Ervin has associated with William E. Yoe for

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### Personals/continued

the practice of family medicine, 806 Earl Frye Blvd. South, Amory.

**B.** Joe Ferguson has associated with the Radiology Clinic for the practice of radiology, 2526 North Fifth Street, Columbus, MS.

Paul Douglas Jackson, of Greenville has been certified as a Diplomate of the American Board of Obstetrics and Gynecology, Inc.

Mitchell J. Myers announces the opening of his office for the practice of neurology, 2500 Fifth Street North, Columbus.

**David F. Mattice** has associated with **Glenn A.** Campbell in the practice of family medicine at Hattiesburg Clinic-West, 104 Millsaps Drive, Hattiesburg.

**David Steckler** has been appointed by the Natchez Board of Aldermen to the Natchez-Adams County School Board.

**Horton G. Taylor, Jr.**, of Ripley has been recertified as a Diplomate of the American Board of Family Practice (ABFP).

Faser Triplett, of Jackson has been honored by the University of Mississippi. The Alumni Center at the University will be renamed for Dr. Triplett at the completion of renovations to the facility.

**Thomas Weldon** of Greenwood was recently named a Fellow of the American College of Surgeons.

Joseph Bingham Witty, Jr., of Columbus would like to announce that he has been recertified by the American Board of Obstetrics & Gynecology, Inc. He took the recertification examination August 2, 1993, in Indianapolis, IN. Dr. Witty was first certified by the Board on November 5, 1982. He is a 1973 graduate of Baylor College of Medicine where he completed a rotating internship in 1973-74. He completed an obgyn residency at Tulane University School of Medicine in 1976-79.

Richard L. Yelverton, of Jackson recently received a three-year appointment as Cancer Liaision Physician for the Hospital Cancer Program at St. Domin-

# Physicians' Recognition Award

# I I

Four MSMA members were named recipients of the AMA Physicians Recognition Award in December 1993. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL
MEDICAL SOCIETY
Robert Odell May, MD

NORTH CENTRAL MISSISSIPPPI MEDICAL SOCIETY Timothy J. Alford, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY John David Seay, MD

SOUTH CENTRAL MISSISSIPPI MEDICAL SOCIETY Steven Barry Liverman, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

ic-Jackson Memorial Hospital. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

# **CME Opportunities**

### **FEBRUARY**

PEDIATRIC NURSING UPDATE 1994
University of Mississippi Medical
Center
February 24, 1994
7:30 AM - 5:00 PM

Research Wing, Classroom R153 School of Medicine Division of Continuing Health Professional Education

(601) 984-1300

### **APRIL**

# PRESCRIPTION FOR THE FUTURE: WHAT WAY HEALTH REFORM? (A MANAGED CARE SYMPOSIUM)

Tulane University Medical Center April 21-22, 1994 Le Meridian Hotel New Orleans, Louisiana Office of Continuing Medical Education

(504) 588-5466 or 1-800-588-5300 Fax: (504) 584-1779

# STATE OF THE ART OF PREVENTION OF HEART DISEASE - CONTRIBUTION OF THE BOGALUSA HEART STUDY - 20TH ANNIVERSARY

Tulane University Medical Center April 27-28, 1994 Westin Canal Place Hotel New Orleans, Louisiana Office of Continuing Medical Education (504) 588-5466 or 1-800-588-5300

(504) 588-5466 or 1-800-588-5300 Fax: (504)584-1779

# PEDIATRIC UPDATE FOR THE PRIMARY CARE PHYSICIAN

Tulane University Medical Center April 29-May 1, 1994 Westin Canal Place Hotel New Orleans, Louisiana Office of Continuing Education (504) 588-5466 or 1-800-588-5300 Fax: (504) 584-1777

### JUNE

# 3rd annual new orleans anesthesiology comprehjensive review & update

Tulane University Medical Center June 5-10, 1994 Hyatt Regency New Orleans, LA Office of Continuing Education (504) 588-5466 or 1-800-588-5300 Fax: (504) 584-1770

# FOURTH ANNUAL MEETING OF THE SOUTHERN ASSOCIATION FOR GERIAT-RIC MEDICINE

Southern Association for Geriatric Medicine June 9-11, 1994 Westin Resort Hilton Head, South Carolina Department of Education (205) 945-1840

### 39TII GREAT SMOKY MOUTAINS PEDI-ATRIC SEMINAR

University of Tennessee Medical Center At Knoxville June 9-11, 1994 Park Vista Hotel Gatlinburg, Tennessee Continuing Medical Education 1924 Alcoa Highway, D-116 Knoxville, TN 37920 (615) 544-9190

### FIRST ANNUAL MEETING OF THE SOUTH-ERN ASSOCIATION FOR FAMILY PRAC-TICE

Southern Association for Family Practice
June 23-25, 1994
The Woodlands
Williamsburg, Virginia
Department of Education
(205) 945-1840

### **JULY**

# SEVENTH ANNUAL MEETING OF THE SOUTHERN ASSOCIATION FOR ONCOLOGY

Southern Association for Oncology July 28-20,1994 Jekyll Island Club Hotel Jekyll Island, Georgia Linda Willingham, Coordinator, SAO, PO Box 190088, Birmingham, AL 35219-0088 (205)942-0530

### 18TH ANNUAL UPDATE IN NEURO-SCIENCE

McGuire Research Institute July 20-23, 1994 Cavalier Resort Virginia Beach, Virginia Pat Harmon (804) 230-1316

### **AUGUST**

### SOUTHERN ORTHOPAEDIC ASSOCIATION

1994 Annual Meeting August 19-21, 1994 The Southampton Princess Bermuda Linda Willingham, Coordinator (205) 945-1848

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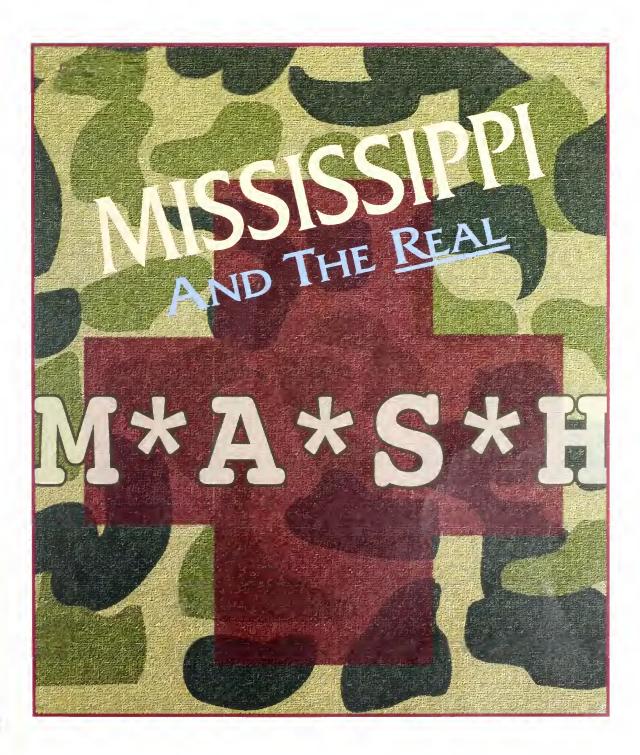
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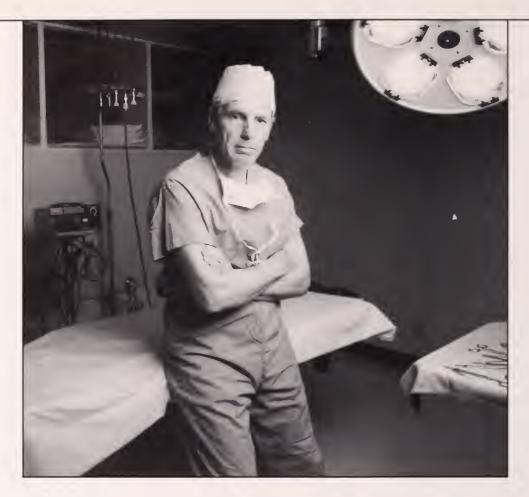


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## **Dateline**

## Journal of the Mississippi State Medical Association Volume XXXV, Number 3

## 126th Annual Session Scientific Exhibits

The MSMA 126th Annual Session will be held May 11-15, 1994 at the Ramada Plaza Hotel, 1001 E. County Line Road, Jackson, MS. Physicians who would like to reserve Scientific Exhibit Space should write: Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229 or Fax the following information to (601)352-4834.

### The request for exhibit space should include:

- (1) the title of the exhibit;
- (2) the author(s) of the exhibit;
- (3) an estimate of the amount of exhibit space needed (MSMA will provide a table only all other materials are the responsibility of the exhibitor); and
- (4) a brief synopsis of the subject to be exhibited.

## State Syphilis Rate Highest in Nation

Jackson, MS — Syphilis is thriving in Leflore and Hinds counties and infecting Mississippians at a higher rate than anywhere in the nation. State Health Officer Dr. Ed Thompson said 68.4 Mississippians per 100,000 have the curable, sexually transmitted disease — almost seven times the national average of 10.6 people per 100,000.

The most startling numbers come from the Delta's Leflore County where the rate is 385.6 per 100,000. In Hinds county, the rate stands at 91.6 cases per 100,000. "There is an epidemic of syphilis in Mississippi, and we have to focus our attention on curing this disease," Dr. Thompson said.

Recommendations to combat the disease include:

- Increase clinical services for syphilis patients, expand existing clinic hours and possibly open new clinics.
- Expand the staff of about 40 disease intervention specialist by 12.
  - Increase public education about the disease through advertising.
- Begin community-based educational programs in Hinds and Leflore counties.

The disease flourishes as the crack cocaine industry blooms. "This problem is a major force behind the epidemic," Thompson said.

Men and women in need of a fix of the highly addictive crystallized cocaine have adopted prostitution as a sex-for-crack act. Sexual encounters are frequent and with various partners, health and law enforcement officials observe.

Dr. Alfio Rausa, the Greenwood-based district health officer for Leflore and surrounding counties, said he treated a patient who prostituted her-

\* \* :

Syphilis Rate - continued

## MFMC Conducts PRO Update Workshop in March

More New AIDS Medicines Tested self for 50 cents per act of intercourse to earn enough money for a \$20 rock of crack. "She has a total loss of personal identity." he said.

Most syphilis cases are seen in teenagers and adults in their mid-20s, statistics show. Babies born to infected mothers can suffer lifethreatening side-effects if they survive to full term.

Statistics paint the problem as a tragedy primarily among black Mississippians. Of cases reported, 95 percent are among black residents and 57 percent of those are women.

Economic inequity, not race, is what fosters an unhealthy life-style, said Lee Arnold, health program specialist for the State Health Department's District 5, which includes Hinds County.

Apathy, joblessness and a deadened sense of moral obligation to alert sexual partners about the disease have Leflore Countians in a deadly pattern, Dr. Rausa said. "We see people who do not care and feel like they are not responsible."

\* \* \*

Jackson, MS — The Mississippi Foundation for Medical Care, peer review organization (PRO) for the state, has scheduled the next series of PRO Update workshops focusing on cooperative quality improvement projects for March 10 at the Holiday Inn Beachfront in Gulfport, March 24 at the Executive Inn in Tupelo, and March 30 at the Ramada Inn Coliseum in Jackson.

Registration for each workshop will begin at 8:30 a.m., with the program beginning at 9 a.m., and concluding around 3:30 p.m. Workshop participants will be provided with hands-on experience using data and statistical tools to help them develop their own quality improvement projects. Participants will also see a demonstration on improving managed care systems with the use of electronic certification.

There is no charge to attend the workshops and all interested persons are invited. Hospital administrative and medical personnel involved in quality assurance or continuous quality improvement projects will find the workshop especially useful.

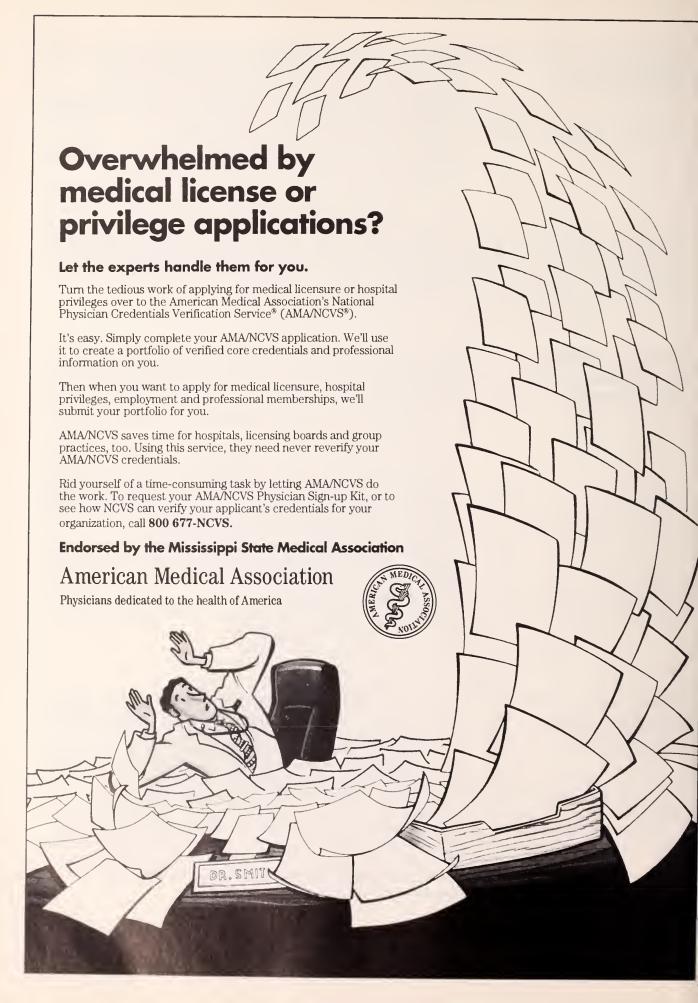
For further information or to register for a workshop, contact the MFMC Outreach Department at 354-0304.

\* \* \*

Washington, DC — For the seventh consecutive year, research-based pharmaceutical companies have increased the number of new medicines and vaccines in development to prevent, cure and treat AIDS and AIDS-related conditions. Seventy-four companies now have 103 medicines in human clinical trials or awaiting approval at the Food and Drug Administration (FDA)— up from 46 medicines in 1988 and 91 in the last survey by the Pharmaceutical Manufactures Association in 1992.

With AIDS of increasing concern to women, children and minority groups, 74 research projects include women and ethnic and racial minorities in the clinical trials. Sixteen research projects include children in the clinical trials. Nearly half of those being tested are in development to treat opportunistic infections, which account for 90 percent of AIDS-related deaths.

\* \* \*



# CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

## Clinicopathologic Conference V

Selection and Preparation: Todd Adkins, MD Matt Rees, MD Francesco Simeone, MD

Joe C. Files, MD, Editor

Differential Diagnosis: Robin Isaacs, MD
Radiological Findings: Anne Halsell, MD
Pathological Findings: E. Rhyne Flowers, MD

#### **CASE PRESENTATION**

A 59 year old woman was admitted to the hospital for evaluation of a lytic lesion of the right humerus and a draining ulcer overlying the bony lesion.

The patient presented to her local physician four months prior to admission complaining of a mass in her right upper arm. The mass was apparently felt to be superficial and was removed by her local physician. Pathological examination of the tissue revealed nonspecific chronic inflammation with the presence of giant cells and necrosis extending to the subcutaneous tissue. The excision site did not heal completely and she had recurrent abscess formation despite repeated courses of oral antibiotics and local wound care.

She was referred to the Surgery Clinic at the University Hospital where she was found to have an abscess along the lateral aspect of the right mid humeral area. After removal of a crusty overlying exudate, approximately 3 milliliters of pus was drained from the wound. The patient was begun on Cephalexin 500mg three times a day and continued local wound care. In the two months prior to admission she was seen twice in clinic where the ulcer showed little or no signs of improvement. Radiography of the

right upper arm was obtained and showed a 3cm lytic lesion in the mid shaft of the humerus. A chest x-ray was done which showed diffuse bilateral reticulonodular interstitial infiltrates as well as several bullous lesions in the left lung apex. Additionally there was volume loss of the right upper lobe and slight tracheal deviation to the right. She was admitted for further evaluation at this time.

Her past medical history included hypertension and osteoarthritis involving both knees and shoulders. There was a questionable history of hypothyroidism which could not be confirmed by chart review. Her only surgery was thirteen years prior to admission when she had a hernia repaired. The patient denied any history of alcohol or tobacco use. There were no known allergies. Her medications at the time of admission included Naprosyn 375 mg three times daily; Aldomet 250 mg/ Hctz 25 mg. each morning; and Halcion 0.125 mg at bed time. Her family history was not remarkable.

She denied any history of fever, chills, night sweats, weight loss, cough, hemoptysis, or shortness of breath. She did complain of occasional anthralgias, headaches, and insomnia. There is no history of tuberculosis, or tuberculosis exposure. She has never traveled out of the country and has not traveled recently.

Physical examination revealed a blood pressure of 130/70, a pulse of 82, respirations at 18 per minute, and a temperature of 97.7. She was well developed and nourished and in no distress.

She was fully alert and oriented. Head and neck examination were normal except she was edentulous. The lungs were clear bilaterally. The heart had a regular rate and rhythm without rubs, murmur, or gallop. The abdomen was soft, non tender, without hepatomegaly. The spleen was palpable two fingerbreadths below the left costal margin in the mid clavicular line. Examination of the extremities showed no clubbing, cyanosis, or edema. There was a one centimeter ulcer in the mid portion of an otherwise well healed surgical scar on the lateral aspect of the right upper arm. The area surrounding the ulcer was not erythematous nor swollen. There was a minimal amount of granulation tissue present. Neurological examination was normal.

Laboratory tests at the time of admission included: Sodium 138; potassium 3.5; chloride 104; bicarbonate 25; BUN 12; Creatinine 1.3; glucose 184; WBC 3200; neutrophils 60%; lymphocytes 27%; monocytes 8%; hematocrit 33.8; platelets 218,000; ESR 119; PT 13.5; PTT 31.3; total protein 9.0; Albumin 3.1; GGT 74; GPT 28; GOT 29; LDH 142; CPK 75; total bilirubin 0.6; calcium 9.6; phosphorus 2.8.

Upon admission fungal immunodiffusions were

drawn but the results were not immediately available. A three-phase bone scan was done which showed an area of increased uptake in the mid shaft of the right humerus. A CT scan of the right humerus was performed which also demonstrated the lytic lesion of the right humerus. The adjacent soft tissues did not show any abnormalities. Computerized tomography of the chest revealed scarring and cavitation in the left lung field, bronchiectasis in the right lower lobe, and some small lymphadenopathy in the mid mediastinum on the right. Abdomen and pelvis computerized tomography showed an enlarged spleen, multiple small gallstones in the gall bladder, and a slightly prominent uterus. Bilateral mammograms were normal. A tuberculin skin test was placed which was negative and a positive candida control. A thyroid ultrasound was done which showed a small hyperechoic area within the right lobe measuring approximately 4.5 mm in diameter. A serum protein electrophoresis was done which showed hypoalbuminemia and a polyclonal gammopathy. Several routine cultures previously taken from the right arm were all negative. Sputum acid fast smears were also negative. A diagnostic procedure was then performed.

Dr. Halsell: The chest X-ray shows the heart to be within normal limits. There is mild fullness of the mediastinum which could be vascular in nature. Diffuse parenchymal and interstitial changes are present throughout the lung fields; the interstitial changes are most severe in the left upper lobe and in the right mid lung field. There are very vague, small nodular densities scattered throughout both lung fields. In addition, there is a band-like area of consolidation in the right mid lung field. Some bullous changes are present in the left upper lobe. The CT scan shows minor lymphadenopathy anterior to aortic arch; this corresponds to the band-like area of consolidation present on the chest X-ray with adjacent inflammatory changes. Increased interstitial markings are present at both hila, which also can be seen, in retrospect, on the chest X-ray. These changes could be inflammatory or from chronic scarring. The radiograph of the right humerus demonstrates a lytic lesion in the mid humeral shaft. The lesion is eccentrically located, has well-defined borders which are not sclerotic, and there is a very fine periosteal reaction. The bone scan shows increased uptake in the mid shaft of the right humerus. CT scan of the humerus shows the eccentrically located lesion which is demonstrated to extend through the cortex. The soft tissues do not appear to be affected.

Dr Isaacs: We will review briefly the salient clinical

features of this case. She is a 59 year old immunocompetent African American female. There is no known history of travel outside of the state. Her presenting complaint is a lytic lesion in the right humerus with an overlying inflammatory mass. On the basis of the clinical picture, the histopathology, and the bone scan, I have interpreted this to be an area of chronic osteomyelitis. It is impossible to assess whether the cutaneous ulceration represents a chronic ulcer at the site of the surgical incision or is a chronically draining sinus. The biopsied material showed evidence of chronic inflammation with the presence of giant cells; there was no evidence of malignancy. The other striking component of the history is the extensive asymptomatic pulmonary disease. The chest X-ray and CT scan show extensive interstitial changes with a diffuse reticulonodular pattern. Finally, she is hypothyroid with an abnormal thyroid ultrasound. The reported laboratory results are consistent with a chronic inflammatory process, including an elevated ESR, a mild decrease in the serum albumin, and a polyclonal gammopathy. Apart from the arm findings, the only other pertinent physical finding is splenomegaly.

In summary, the patient is an African American female with chronic osteomyelitis and asymptomatic pulmonary disease. We can broadly consider the diagnostic possibilities in three main groups; infection, malignancy, and sarcoidosis. Firstly, let us consider the diagnosis of sarcoidosis. The presence of asymptomatic pulmonary disease and chronic osteomyelitis with giant cell formation are certainly compatible with sarcoidosis. Further, African Americans are more likely to have sarcoidosis. However, I believe there are more likely diagnoses and sarcoidosis is a diagnosis of exclusion.

Malignancy is my second major consideration. There is a lytic bone lesion with evidence of cortical erosion and the abnormal chest X-ray could also represent involvement by tumor. This clinical presentation could be consistent with a primary bone tumor with pulmonary metastases or a primary lung tumor with osseous metastases. Other possibilities would include metastatic breast or thyroid cancer. However, the breast examination was unremarkable and the thyroid ultrasound is not consistent with thyroid malignancy. Although histopathology of areas adjacent to malignancy, particularly regional lymph nodes, can show chronic inflammation, I have concluded that malignancy is the not the diagnosis in this patient because the biopsy did not show any evidence of neoplasia.

This leaves us to consider the possibility of infection. The clinical presentation is most consistent with an indolent infection. I have listed in Table 1 the

## Table I — Possible Causes Of Chronic Osteomyelitis

#### 1. Fungal disease

- Most likely diagnoses
  - Histoplasma capsulatum
  - Blastomyces dermatitidis
  - Cryptococcus neoformans
- Less likely diagnoses
  - Coccidioides immitis
  - Sporothrix schenckii
- Very unlikely diagnoses
  - Aspergillus spp.
  - Agents of mucormycosis
- 2. Chronic bronchopulmonary suppuration with metastatic chronic osteomyelitis
- 3. Cat scratch disease
- 4. Mycobacterial infection
- 5. Members of the order Actinomycetales
  - Actinomyces spp.
  - Nocardia spp.

infectious processes which I will consider. I have listed five groups of infectious processes, with the most likely diagnosis listed at the top. I will discuss them in reverse order.

Members of the order Actinomycetales are higher bacteria and the two species which cause human infections are Actinomyces and Nocardia. Both species are Gram positive beaded rods with Nocardia spp. being weakly acid fast. Actinomyces is a commensal in the oral flora and characteristically causes indolent local disease with abscess formation and extension through local tissue planes. Several forms are recognized including cervicofacial, pulmonary, abdominal or cecal, and pelvic forms.3-5 Rarely, disseminated actinomycosis with osseous involvement is seen, but this is extremely uncommon. Nocardia spp. can also cause indolent suppurative infections.6 This is most commonly seen with N. brasiliensis which can cause chronic cutaneous suppuration, particularly involving the lower limbs; osseous involvement is rare. In contrast, N. asteroides tends to cause systemic disease, particularly in immunosuppressed patients. Characteristically it causes pulmonary and brain abscesses, but other sites of infection have been reported. This patient's presentation would be a rare presentation of these infections.

Mycobacteria also cause chronic suppurative infections. A shortened taxonomic classification of the pathogenic non-lepromatous mycobacteria is shown in Figure 1. M. tuberculosis and M. bovis are classi-

fied as tuberculous mycobacteria. Although most commonly associated with pulmonary disease, they can also cause disseminated disease ranging from disseminated miliary tuberculosis to localized osseous or cutaneous lesions. The other mycobacteria listed are referred to as the non-tuberculous mycobacteria or the mycobacteria other than tuberculosis (i.e. the MOTT group). Classically the nontuberculous mycobacteria have been subdivided into four Runyon groups based on the color they produce in culture and by the speed of growth in vitro. In Table 1, I have listed the non-tuberculous mycobacteria which could potentially cause the clinical presentation under discussion. Many of the non-tuberculous mycobacteria, especially the rapid growers, cause chronic skin and soft tissue infection; usually they cause ulceration at the site of inoculation. In general, most of the non-tuberculous mycobacteria do not cause pulmonary disease. The two mycobacteria listed which do cause pulmonary disease are M. avium-intracellulare group and M. kansasii. M. avium-intracellulare group has gained notoriety in the AIDS era but rarely, if ever, causes disseminated disease in immunocompetent patients. In contrast, M. kansasii has a disease spectrum in immunocompetent patients in endemic areas which is very similar to tuberculosis. The negative PPD test, although making tuberculosis a less likely diagnosis, does not exclude tuberculosis as the diagnosis. It certainly does not exclude non-tuberculous infection. However, I do not believe that this patient has a

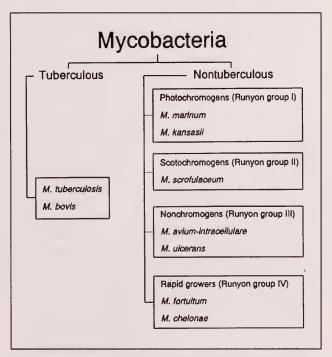


Figure 1 Partial Taxonomy of Pathogenic Mycobacterium spp.

mycobacterial infection primarily because the clinical presentation is not usual.

The next potential diagnosis is cat scratch disease. One could argue that it should not be so high up in the list, but I have deliberately placed it there as a reminder that cat scratch disease must be considered in the diagnosis of chronic cutaneous lesions. Cat scratch disease in its classical form is a syndrome of fever and regional lymphadenopathy following a cat scratch. Although 90-95% of patients present with the classical form, there are variant presentations ranging from abscess formation to osteitis in children to disseminated disease in HIV-infected patients. Recently, a micro-organism, designated Afipia felis, has been implicated as the putative pathogen.8 The clinical features of this case would be very unusual for cat scratch disease.

The next diagnostic possibility is chronic bronchopulmonary suppuration with metastatic osteomyelitis. If we exclude fungal pathogens which we will discuss next, the likely pathogens would include Staphylococcus aureus and Streptococcus spp; pulmonary anaerobes are particularly important in metastatic brain abscess. It is difficult to exclude bacterial infection as the cause of the clinical presentation. The negative bacterial cultures from the surgical specimen do not exclude a bacterial cause, but do make it less likely. However, she had received multiple unspecified antimicrobials which could have been the cause of a sterile culture.

Finally we will consider fungal infection. I have listed a number of potential fungal pathogens in Table 1 and I have grouped them into likely, less likely, and unlikely pathogens. It is important to reiterate that this is a normal, immunocompetent 59 year old woman; we can exclude from our discussion rare immunodeficiency syndromes in which common fungal diseases can cause sinister outcomes. Mucorinycosis is caused by members of the order Mucorales which includes Mucor, Absidia, and Rhizopus. The classic patient with mucormycosis is the uncontrolled diabetic with fulminant rhinocerebral disease.9 Although it can also cause disease at other sites including pulmonary and osseous involvement, mucormycosis is nearly always seen in uncontrolled diabetics or immunosuppressed patients such as patients with leukemia or renal transplants. 10-12 Rarely Aspergillus spp. can cause cutaneous lesions in immunocompetent patients following cutaneous inoculation.13 The more common forms of infection in immunocompetent patients are the formation of an aspergilloma in an old tuberculous cavity,14 or allergic bronchopulmonary aspergillosis in asthmatics.15 In neither clinical situation is there invasive disease. Invasive aspergillosis is generally seen in the immunosuppressed population. 16-18

Sporotrichosis, caused by Sporothrix schenkii, presents in 80% of patients as subcutaneous nodules following the lymphatic supply of the arm and forearm after inoculation at a site on the hand. 19 Inhalational forms of sporotrichosis are also recognized. A disseminated form with cutaneous and osseous involvement is also well described.20-22 However, it is rare for patients with primary pulmonary disease to have disseminated disease. 19 In contrast this patient's clinical presentation is very typical for coccidioidomycosis which commonly presents with both pulmonary and disseminated disease.23-25 However, Coccidioides immitis infection is limited to very specific regions of the United States and Mexico;26 these areas tend to correlate with the lower Sonoran life plane. Mississippi is not an endemic area and there is no history of travel to an endemic area. Although rare cases have been reported in such patients, the lack of exposure history essentially excludes the diagnosis.

The final group of fungal pathogens could all cause this patient's presentation. I will discuss each in turn but I will stress at this point that there are no specific clinical features which will help establish the pathogenic organism. Cryptococcus neoformans is most commonly thought of as a cause of chronic meningitis, but it also commonly causes pulmonary disease. About 10% of patients with pulmonary disease will develop cavitatory lesions. Immunocompetent patients are commonly infected with C. neoformans. About 10% of patients with extrapulmonary cryptococcoses have osseous involvement<sup>28</sup>.

Blastomyces dermatitidis causes chronic pulmonary and osseous disease. It is the commonest cause of admission for systemic fungal disease in the state of Mississippi (SW Chapman, personal communication). It is an inhalation disease in which the majority of patients have an asymptomatic or mildly symptomatic self-limiting primary infection, but some patients may progress to chronic pulmonary disease.<sup>29,30</sup> Pulmonary disease is common and about 10-15% of patients will have osseous involvement.<sup>31</sup>

Histoplasmosis is the other chronic fungal disease endemic to Mississippi. As with blastomycosis, histoplasmosis is an inhalational disease which generally has a self-limiting asymptomatic primary infection. In patients with recrudescent disease, chronic pulmonary disease, often with abscess formation, is common. Disseminated disease including endo-carditis and adrenal gland involvement are also seen 32,33. Osseous involvement is extremely rare 25,32,33.

So we have now considered the possibilities. It is virtually impossible on the basis of the clinical pre-

sentation to differentiate between histoplasmosis, blastomycosis, or cryptococcoses. However, a diagnosis must be reached. My diagnosis is chronic pulmonary histoplasmosis with metastatic bone infection. I suspect the diagnosis was not made with the original biopsy because the material was neither stained nor cultured for fungi. A bone biopsy with appropriate cultures and histopathologic staining should establish the diagnosis. Other diagnostic tests which may be useful in excluding other diagnoses include fungal serology, determination of serum cryptococcal antigen, and microscopic examination of wet preparation prepared from drainage from the sinus.

### Dr. Isaacs's diagnosis:

Histoplasma capsulatum osteomyelitis (R) humerus, metastatic from pulmonary histoplas-mosis

Dr. Flowers: The specimen we received was a needle biopsy of the lytic lesion of the humerous. Basically, we just received some fragments of soft tissue and a few bony fragments. There are also a few aggregates of inflammatory cells. Indeed it is a fungal infection and there is a large histiocyte. There are scattered inflammatory cells, mainly polys and some other histiocytes here. There are small regular sized yeast cells, which look like they are encapsulated, although it's really artifact. There is a clear space around the cells about 2-4 microns. We confirmed it by GMS or silver stain and there are some lying freely in the tissue and the others are within the histiocytes. This is compatable with Histoplasma capsulatum.

2500 North State Street Jackson, MS 39216

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- Dr. Files is Professor of Medicine and Associate Chairman for Clinical Affairs; Dr. Isaacs is Assistant Professor of Medicine; Dr. Flowers is a Resident in Pathology; and Dr. Halsell was a Resident in Radiology, all at the University of Mississippi Medical Center.
- Dr. Adkins, Dr. Rees, and Dr. Simeone were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1991-1992.

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## DOCTORS' DAY — MARCH 30

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MISSISSIPPI STATE MEDICAL ASSOCIATION ALLIANCE

# Medical Writing Conference

# Friday March 25

Mississippi Writers Association P.O. Box 1278 Jackson, MS 39215

Dr. Rob Rockhold will preside over the 1994 Medical Writing Conference to be held at the Primos Northgate Convention Center on March 25th. Our keynote speaker will be Dr. Arthur C. Guyton of the University Medical Center.

George Wynne, Director of the Statewide Community Colleges Foundation will present the Community College Network. CCN is a totally interactive audio and video telecommunications network linking 15 colleges with each other and with the UMMC and MS Cooperative Extension Services for the purpose of training. This technology has dazzled even the jaded national media with its amazing possibilities. CCN, the first application of size and kind, nationwide, was done at a cost of \$1.6 million.

Dr. Patricia Grierson will speak on Science in Literature. Dr. Grierson is a professor of English at Jackson State University with a doctorate in Creative Writing. She teaches Creative Writing and the Literature of Science at JSU. Her work has appeared in over 150 publications.

Speakers include Ginger Cocke, Managing Editor of the Journal of the Mississippi State Medical Association; Dr. Ben Douglas, author of Reset your Appestat and over 250 medical journal articles, chapters, and abstracts; Dr. Julius Cruise, who has not only authored and co-authored over 200 scientific articles, he is the founder and editor-in-chief of two international medical journals, Immunologic Research and Pathology; Dr. Duane Haines, who has authored and co-authored numerous books,

abstracts and chapters in addition to serving as senior editor for a published symposium on brain behavior and reviewer or editor for several journals including the Anatomical Journal; and Dr. Carol Scott-Conner, Professor of Surgery, University of MS Medical Center, author and twice the award winner of MWA's Author C. Guyton Medical and Science Writing Award.

Register early and save \$5 off the full registration fee of \$50 per person. Conference reservations received by MWA on or before March 15th will cost only \$45 per person. Conference reservations received after that date or at the door will be the full \$50. Please include a list of all attendees covered by reservation checks to allow MWA to prepare name-tags. Mail your reservations to Jo Barksdale, MWA Medical Conference, P.O. Box 1278, Jackson, MS 39215. For additional information, call Jo at 352-6864 in Jackson.

In conjunction with this conference, Cabot Lodge/Millsaps is offering a Special Medical Conference Rate to those who call for the special reservation card. This not only entitles the holder to the special rate but includes the Hospitality Reception with complimentary cocktails every evening and a Deluxe Continental Breakfast. Be sure to ask for the MS Writers Association/Medical Division Group Rate Card. Call 1-800-874-4637 or 948-8650 in Jackson for your group reservation card.

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## **Special Article**

## Mississippi and the Real MASH

Lucius Lampton, MD



Dr. Richard Hornberger (left), author of the novel MASH, holding a football in front of "The Swamp" in 1952. On the right is Dr. Jim Dickson, his tent-mate. Hornberger and Dickson were (respectively) the fictional Hawkeye and Trapper John. Note the literary emblem of Somerset Maugham painted on the door.

In Korea from 1950 to 1953, the United States of America was entangled in one of the most devastating conflicts ever waged between the West and communism. Although 33,729 Americans died and over 103,000 were wounded, no prominent Korean War memo-

rial exists and the war itself has largely been forgotten except by participants and historians. The most memorable aspect of this least remembered war is its inspiration of the bestselling novel MASH, which in turn spawned a popular movie and an even more popular

television series. Few MASH aficionados realize the critical role two Mississippians played in author Richard Hornberger's writing of the original novel. A Tupelo surgeon was Hornberger's closest friend while the two served in a real MASH in Korea, and a Co-

lumbus surgeon served as Hornberger's commanding officer.

MASH is an acronym for Mobile Army Surgical Hospital. Later, in the movie and the television series, three asterisks were added to the title, one in between each of the letters. A MASH was a new concept devised by Major General George E. Armstrong, The Surgeon General of the United States Army, and as a concept, it had evolved from experience during the latter stages of World War II (See Surgery in World War II: The Physiologic Effects of Wounds, by the Board for the Study of the Severely Wounded, U. S. Printing Office, Washington, D. C., 1952). It was a hospital equipped and staffed to do major surgery that would move as the battlefront moved, always remaining just a few miles behind the front line. Central to the MASH concept was the rapid evacuation of the wounded back to the hospital. The MASH unit in Korea was responsible for the casualties of an entire army, and they treated not only American casualties, but those of other United Nations participants: Belgians, French, Ethiopians, Canadians, Australians, Filipinos, Thai, and others. The MASH also treated a number of Chinese POWs.

The use of helicopters in transporting the casualties from the battlefield to the MASH was an innovation with the Korean War, and it was utilized heavily by the MASH units. There were 3 MASH units in Korea, positioned at strategic intervals across the peninsula. Hornberger's MASH unit was the 8055th which became the 4077th MASH in the book, affectionately called the Double Natural. The 8055 was by far the busiest MASH unit, supporting the most active section of the Korean war front. The 8055 was located along the 38th Parallel, directly north of Seoul, Korea's capital. The unit had about 22 physicians, 30 nurses, 150 enlisted men, and two medical service officers.

A MASH was not the first time tents near the front had been used for hospitals. Rather, MASH was the culmination of almost 200 years of American military field hospitals. When George Washington's Continental forces gathered outside of Yorktown, Virginia in 1781, the Scotland-born Dr. James A. Craik. the army's chief physician and surgeon, organized and directed a field hospital. During the siege, Craik battled small pox, foul water, and a lack of blankets and other supplies while attending the needs of Washington's army. In a later American revolution, field hospitals continued to evolve. An especially significant field hospital was established during a Civil War battle which took place just miles north of Mississippi's border with Tennessee. During the battle of Shiloh in April of 1862, Union Assistant Surgeon Bernard J. D. Irwin had commandeered several unused tents and set up a field hospital very near the front while the battle still raged. On the second day of the battle, Irwin enlarged his hospital of tents to 300 beds, and noted that wounded soldiers treated on the field fared much better than wounded shipped out on riverboats for later treatment. Irwin's success at Shiloh would encourage the further development of field hospitals, and was a direct ancestor of Korea's MASHs.

In his novel's foreword, Hornberger describes the MASH units of Korea: "Most of the doctors who worked in Mobile Army Surgical Hospitals during the Korean War were very young, perhaps too young, to be doing what they were doing. They performed the definitive surgery on all the major casualties incurred by the 8th Army, the Republic of Korea Army, the Commonwealth Division and other United Nations forces. Helped by blood, antibiotics, helicopters, the tactical peculiarities of the Korean War, and the youth and accompanying resiliency of their patients, they achieved the best results up to that time in the history of military surgery.



A Bell helicopter at the 8209th MASH. Dr. Kellum remembers riding to Chunchon in this chopper. Helicopters were totally new to the battlefield and were utilized in Korea in the transport of casualties.

"The surgeons in the MASH hospitals were exposed to extremes of hard work, leisure, tension, boredom, heat, cold, satisfaction and frustration that most of them had never faced before. Their reaction, individually and collectively, was to cope with the situation and get the job done. The various stresses, however, produced behavior in many of them that, superficially at least, seemed inconsistent with their earlier, civilian behavior patterns. A few flipped their lids, but most of them just raised hell, in a variety of ways and degrees."

### HORNY AND HAWKEYE, GRIP AND DUKE

H. Richard Hornberger, a resident of Waldoboro, Maine, wrote the novel MASH, which was published in October of 1968, under the name Richard Hooker. Of his Hooker pseudonym, Hornberger states: "I did not want to use my own name and just picked it out of the air. Somebody said it would be a good idea to call me Hooker because that is the way I hit a golf ball. I've never hit one straight in my whole life." Like his character Benjamin Franklin "Hawkeye" Pierce, Hornberger in Korea was called by a nickname: "Horny." Says Hornberger, "I and my father before me were always called 'Horny.' It is a natural abbreviation of Hornberger. I suppose when they started using it the sexual connotation hadn't taken hold. For me it had no meaning beyond the fact that my name is Hornberger and people called me 'Horny.'" When asked what his first initial stood for, Hornberger avoided an answer by poking fun at his Mississippi friend Grip Kellum: "I won't tell you what the 'H' stands for, but my first name is worse than Agrippa."





Dr. Agrippa "Grip" Kellum, above left, the inspiration for the character Duke Forrest, and at right, during his Korean years.

Hornberger's closest friend during his time in Korea was Tupelo surgeon Agrippa Spence "Grip" Kellum, M. D. Kellum states, "He [Hornberger] and I lived in the same tent together." Kellum was born in 1923 at Guntown, Mississippi, a rural hamlet north of Tupelo. After finishing his undergraduate education at Ole Miss, he attended Ole Miss's two year medical school and transferred to Harvard, where he earned his M. D. in 1948. He did his postgraduate training at Grady Hospital and Emory University in Atlanta, Georgia. After his third year of surgery training, Kellum went to Korea as a surgeon for an evacuation hospital south of Seoul. He soon was placed on a neurosurgery team which was sent to a MASH unit, the 8209th. "All the doctors," says Kellum, "wanted to get into a MASH." After arriving at the 8209th, his neurosurgery team dissolved and he was shipped to the 8055th MASH, which is where he met Hornberger, who was already stationed there. The two surgeons were tent-mates and soon became close friends. "We used to call him 'the Gipper' in Korea, or at least that was what I called him. Have one for the Gipper, I'd say," says Hornberger, who adds that he and Kellum "were real close friends

and still are."

The author notes in the book's foreword: "The characters in this book are composites of people I knew, met casually, worked with, or heard about. No one in the book bears more than a coincidental resemblance to an actual person." Despite this assertion, Hornberger concedes the resemblance of Agrippa Kellum to Captain Augustus Bedford "Duke" Forrest. Agrippa "definitely" inspired Duke, states Hornberger, who adds that "Duke Forrest and Grip Kellum are about the same."

Duke and Kellum are alike in many ways. Says his commanding officer Henry Holleman: "Kellum was personable and very witty, much like the Duke Forrest character." Hornberger writes in the novel that Duke "was the most amiable, and therefore likeable" of the MASH surgeons. However, one slight difference is that though both are Southerners, Duke is from Forrest City, Georgia, not Guntown, Mississippi. "The reason he [Hornberger] made Duke a Georgian is because I trained at Grady in Atlanta," says Kellum, who asserts, "However, I am very much a Mississippian, he knows that. I love Mississippi." Like the character Duke, whose name seems an allusion to the famous Confederate cavalryman Nathan Bedford Forrest, Kellum's knowledge of and references to the Civil War are extensive.

The novel MASH ends with Duke and Hawkeye's poignant sea and air journey back home to the USA. Hornberger states that he and Grip Kellum took a similar journey together which inspired the novel's ending. "The last chapter of MASH is a pretty accurate account of our trip home," the author says. Kellum agrees and adds that he and Hornberger "came back together on a boat from Korea to Japan and from Japan to Seattle. Then we flew to Chicago together." From Chicago, Hornberger went home to Maine and Kellum went to New Orleans, where he joined his wife, whom he had married in 1946. By 1955, Kellum had returned to his Mississippi home of Tupelo, where he has resided since.

#### THE REAL COLONEL BLAKE

Jeremiah Henry Holleman, Sr., M. D., a Columbus surgeon, was the real MASH's beloved commanding officer, and in that position, influenced the MASH character Lieutenant Colonel Henry Braymore Blake, head of the 4077th MASH. "In Korea he went by Jerry, but I know that he's Henry now," says Hornberger. The son of a sawmill owner and farmer, Holleman was born in 1916 near Pickens, Mississippi, fifty miles north of Jackson. He graduated from Millsaps College in 1939 and like his later friend Grip Kellum, attended the Ole Miss Medical School at Oxford for two years. After obtaining his M. D. from the University of Tennessee at Memphis, Holleman interned at Birmingham, Alabama for nine months, an abbreviated period mandated by the military, which then called him to active duty. The storm clouds of World War II had long been swirling, and with three months left as a medical student, he had been inducted into the army with the understanding that as soon as the army could call him he would report for duty as a medical officer. Armed with his abbreviated internship, Holleman was shipped to the European theatre as a Battalion Medical Officer, arriving at the time of the Battle of the Bulge. After VE day, Holleman returned home for three weeks to be with his new wife, Agnes, and just as he was about to be shipped out to the Japanese theatre, the atom bomb was dropped, and he soon was discharged from the army. After finishing a surgery residency in Birmingham, Holleman moved to Columbus, Mississippi. Holleman was a man who enjoyed military life, so he joined the National Guard. When hostilities erupted in Korea, his National Guard unit was mobilized, and he was pulled out of his artillery unit and assigned to a medical unit. At the age of 35, Holleman was the commanding officer of the 8055th MASH, as well as the unit's senior surgeon. He would later be awarded the Order of the British Empire by Queen



A confident Dr. Henry Holleman, the inspiration for Colonel Blake, in his field army uniform, at right, and above, Dr. Holleman today shown with his fishing lure collection.

Elizabeth for his services in the Korean War.

The book's author was not aware of his friend Holleman's passion for fishing when he wrote the novel, and the novel's commanding officer has no obsession about fishing. Hornberger relates that Holleman's great contribution to the character Henry Blake came not in the novel but rather in the production of the movie. While preparing to film the movie, its producers and writers interviewed several of Hornberger's Korean War buddies, hoping to uncover details to portray the war experience as accurately as possible. Holleman was among those interviewed and apparently his own personality and interests attracted the attention of the movie's production staff, who included a heavy dose of Henry Holleman in their revised Colonel Henry Blake character. "I don't remember that I had Henry Blake as a fisherman," says the author, "That was something they did in the movie. The movie producers interviewed Holleman and found out about his interest in fishing. In fact, when I saw the movie I still didn't know about Jerry's fishing. Blake's fishing cap certainly wasn't my idea. The character of Henry Blake actually was based more on Jerry Holleman's



successor than it was on Jerry. Blake is not a very sympathetic character in the book, or at least that was how I meant to portray him. I meant him to be kind of a jerk, which is what Holleman's successor was. But Holleman, he was a wonderful commanding officer and a wonderful person. He was the guy we all admired and respected." And although Blake in the movie did possess many of Henry's traits, including his middle name, Hornberger is quick to point out that Holleman was universally respected by the physicians he commanded: "Jerry was not anybody that anyone would try to run over. He did a great job. And he loved his work."

Kellum had known of Holleman's fascination with fishing while the two served together in Korea, although Kellum had not realized his commanding officer was actually a "rabid fisherman." While Holleman did not wear a fishing hat and a fishing vest in Korea, Kellum states that his old c. o. "will climb mountains to go fishing." And Henry did fish in a river that ran behind the MASH. "We would swim and fish in it. I don't think we ever caught any fish out of it, but we tried," says Holleman.

Holleman's obsession endures forty years later, and today he possesses one of the nation's finest fishing lure collections. In a downstairs office at Holleman's Columbus home, more than a dozen cases display thousands of his lures. Some date back to 1852 and many are worth thousands of dollars each. His lure collection began eleven years ago, after he inherited his father-in-law's old tackle box. Looking through the Holleman found several old baits which he had not seen before. Especially peaking his interest was a "Wotta Frog" lure, which got him thinking about "old-time baits." His patients soon learned of his interest and began bringing him tackle boxes by the dozens. His collection grew and today he is an avid life member of the National Fish Lure Collector's Club.

The genial, warm, and witty Holleman was without a doubt a laid back commanding officer of the MASH, but he stresses that he did not let his physicians manipulate him. Holleman states of 8055: "Everyone was a professional. They all knew they had a job to do. As long as people did their job, I didn't care if they didn't have their shoes shined. We didn't really go in for a lot of spit and polish." Kellum remembers his c. o. as "pretty much G. I." in style, because he always had to set a good example for his men. "Whereas," continues Kellum, "Horny and I could do almost anything we wanted to and we did."

Holleman had been in command of the 8055 for two months when Hornberger was first assigned to the unit. "I immediately liked Horny," says Holleman. "He was congenial and a very funny guy, but also a very serious surgeon. He had been kicked around in the Army to several different places, to the point that he thought he was a misfit. He told me he went to the MASH so he could do surgery...everyone called him Horny, including the nurses and he was always quoting and writing witty poems." Kellum notes that the real Hawkeye was no political liberal, but rather very conservative. "He hasn't changed a bit," says Kellum, "He's just an old gruff right-winger." None of the surgeons in their tent, says Kellum, had any "outspoken leftist leanings."

The MASH character Trapper John McIntyre, the thin Boston chest-cutter, was very closely based on the third man in Hornberger and Kellum's tent, Jim Dickson,

M. D., a New York thoracic surgeon. According to Kellum, Dickson was a "very intellectual sort," somewhat of an eccentric genius who left clinical medicine to work at the National Institutes of Health, eventually serving as Deputy Assistant Secretary of Health and afterwards as Assistant Surgeon General under C. Everett Koop. Holleman calls Trapper John "very brilliant, but a private kind of person," who was "a very good surgeon."

#### LIFE IN THE SWAMP

"The Swamp" was officially Tent Number Six, named in the novel by Hawkeye after the name his college apartment. Hornberger states that in the real Korea there was also a tent called "The Swamp." He adds that "Trapper John did that," noting that Jim Dickson's college room had been designated The Swamp, and the real Trapper John had carried the name to Korea. Living in The Swamp were Hornberger, Kellum, and Dickson, the inspirations for Hawkeye, Duke, and Trapper John, respectively. Kellum, "There were 3 of us in the tent. I don't know how large the tent was. It was a fairly large tent, sixteen by sixteen. And we called it The Swamp." Hornberger describes The Swamp in his book: "Tent Number Six, the home of Forrest, Pierce and McIntyre, became a center of social activity. It also became known as The Swamp, partly because it looked like the kind of haunt one might come across in a bog and partly because Hawkeye Pierce, while in college and unable to afford a dormitory room, had lived just off the campus in a shanty that his classmates had called The Swamp. The words, in big capital letters -- THE SWAMP -- were painted in red

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on the door of Number Six." Upon looking at photographs of the real Swamp, one realizes that the movie's Swamp was an accurate replica. Says Hornberger, "They had pictures that one of us had sent. So they did have an exact reproduction of The Swamp in the movie."

On the side of The Swamp in both reality and the movie was an

African symbol used by Somerset Maugham (1874-1965) as his adopted literary emblem, adorn-



ing many of the covers and title pages of his numerous books. Interestingly, this British novelist, the author of such books as Of Human Bondage and The Razor's Edge, was also a physician, and in the eleventh chapter of MASH, the Swampmen are reading some of Maugham's short stories. For the Swampmen, Maugham's emblem was, according to Kellum, "a symbol to keep the evil eye away," placed on the tent's front door by Dickson as a good luck charm.

Holleman describes the contents of a typical tent: "a cot, a table, a chair, and in the winter time it would get real cold so we had a little oil heater." There were Korean houseboys and a "rag-tag squad of Korean kids" who waited on tables. "Each doctor's tent at the MASH," writes Hornberger, "had a young Korean to clean it, keep the stove going, shine shoes, and do the laundry and other chores. He was called a houseboy. Naturally, The Swainp's houseboy was called a Swamphoy." Although there was little interaction with other Korean civilians, the MASH physicians got to kill v well the Kirean employees. Holleman adds. We had a number of Korean unplayed by the hospital for labor for di ha ching, for cleaning surgical instruments, and as assistants at the hospital."

#### THE REAL MASH

The book MASH begins in November of 1951, and continues for the next eighteen months of Hawkeye and Duke's tour of duty. "None of us wanted to be there. I think I had in the book that Grippa hadn't changed his fatigues for three months because he wasn't going to change them till he got orders to go home. We wanted out very badly," says Hornberger. Holleman asserts that the book and movie realistically portray operating conditions at the actual MASH: "We were in tents most of the time. Along towards the end of the war, we did get into some semi-permanent buildings when the front stabilized. There was not much movement of the front at that time. We only moved once the year I was there. We were a mile and a half to two miles from the fighting. We could see tracers from the machine guns and the artillery barrage would often light up the sky," says Holleman. Kellum notes, "When you first opened up a MASH you were on the dirt floors, then they'd put down some wood floors and make the camp a little nicer. But if you had to move, it was back into the tents." Unlike the movie and television series, there was no loud speaker system at the real MASH. In regard to the MASH's location to the front, Kellum comments, "A mile did not make any difference, but if one had to go ten miles further, for the wounded that would make a big difference. Even though we had helicopters, most of our wounded came in by overland ambulance. Only the most seriously wounded were transported by helicopter."

The helicopters had pods on their sides, and Holleman states that "the walking wounded would be on the inside of the helicopter with the more serious injuries riding in the pods reclined." Holleman recounts riding a helicopter once to pick up a casualty: "Flying over a mountain, we went to the fighting. As we approached the coordinates we were going to we saw a little puff of smoke. Those on the ground had set off a smoke bomb to show us exactly where to land. From the time that boy was wounded to the time he was in the hospital being treated was about 30 minutes. Back in World War II it would have taken days."

Upon arriving at the MASH, the patients would first be seen by the triage officer at receiving. When a patient came in, the first thing they did was cut his clothes off and examine him from head to foot, including a rectal to be sure there was no blood in the rectum, for, according to Holleman, "many times if a patient had his leg blown off, he might also have a belly wound and not even know it." Then on to the pre-op ward where IVs and transfusions were started, and xrays obtained. Kellum notes, "We had little field xray units just about like the old portable machines that were in our US hospitals. We even did carotid arteriograms, berry aneurysms were common. We had the developer and fixer tanks and xrays came out just like xrays of 1993." The operating room was five tables side by side in one long building, and though the tents were dark, each table had a spotlight. After the surgery, the MASH would keep the soldiers until they were ready for transport to Japan.

The MASH saw all sorts of injuries. From large and small shell fragments to land mine explosions to sniper bullets, the wounds were varied and often devastating. Vascular surgery was in its infancy at the time of the Korean War. Grip



The state of the art operating room in Korea, vacant during a lull.

Kellum contends that the real MASH contributed significantly to the evolution of vascular surgery. "This was the first time vascular surgery was done on any basis where you outline a way to do it and then do it," says Kellum. The MASH surgeons did a great many vascular repairs, and Dickson even took out a foreign body from one of the heart chambers. Hornberger writes in his novel, "Most of the surgeons had some locally acquired experience in the care of arterial injuries, but they were still beginners. Therefore the Army had sent a Professor of Vascular Surgery from Walter Reed Hospital in Washington to give lessons throughout Korea." This happened, for Holleman states that his surgeons did not have much training in vascular surgery, so a vascular surgeon from Walter Reed came to the front and instructed them: "Some dogs were rounded up and we had dog surgery on the war front to see the arteries. We learned how to sew blood vessels by practicing on dogs. We had a lot of amputations before that course, and after it we had a lot fewer." Hornberger writes in a later chapter, "Arterial injuries were not unusual, but this night they caught two. Trying to save the right leg of a G. I. from Topeka, Kansas, and the left leg of a Tommy from Birmingham, England, Duke and Hawkeye did two vein grafts to bridge the arterial gaps blown out by gook artillery."

In Grip Kellum's possession is a letter addressed and mailed to him by a British soldier on whom he had operated. The grateful soldier writes, "You may remember me as I was brought into 8055 M. A. S. H. on the evening of the 21st of Sept with a wound in my right thigh which included a severed artery. You operated shortly after I arrived and were able to repair the artery. If I remember rightly I took everything as a matter of course and was duly sent to 121 in Seoul then to the British Hospital and then by airvac to my present position [British Commonwealth General Hospital in Kure, Japan]. At each of these places I have been assured that I am fortunate to still have my leg and have come to realize that I have you to thank for the skill with which you repaired my artery" (Lt. Douglas A. Oliver to Kellum, undated letter).

"Vietnam," writes Kellum, "was far more sophisticated than Korea. They had dialysis and respirators. They defined the term ARDS (Adult Respiratory Distress Syndrome) -- what caused it and how to handle it. I'm sure we had ARDS in Korea, but probably called it multiple systems failure and lost some or most of them. Most of the ones we lost were 'basket cases' or a screw up of some kind. This was rare, but did happen." The modern MASH units are complete with space age technology, much of which was not even dreamed of in 1951. Kellum notes that "a modern MASH is quite a complete medical facility, capable of dealing with nuclear, chemical, and biological casualties."

In Korea, the laboratory conditions were poor at best. Holleman states that they at the MASH could "do a hemoglobin and a white count, CBC, but no electrolytes" or other laboratories: "If we wanted a blood chemistry, we would have to send the sample back to Seoul." The MASH had plenty of surgical supplies and no shortage of blood. "We used an awful lot of blood. We treated a lot of ruptured spleens and kidneys and shot guts and livers and legs. Many times the casualties would be in shock when they'd get to us," adds Holleman. "We treated over 5,000 casualties the year I was there with a 97% survival. We were written up at the time in JAMA as having the best record of survival in military history."

Besides the vascular innovations, other common medical items were just coming into use in Korea. One was curare, and a prominent sign at the MASH stated in questionable Latin, "Curarum Omnes Fixo": curare fixes all. There was also a 38th Parallel Medical Society consisting of the medical personnel in all the MASH

units. The Society met at the 8055 once a month to discuss cases. "Treatment of shock filled many of the discussions, and so did several things now obsolete, such as intra-arterial transfusions and doing tracheotomies to reduce the dead space," says Holleman.

The MASH was more than just medicine. Impressive in the novel, movie, and television series are the many sexual relationships implied between the physicians and the nurses. This was somewhat exaggerated in all mediums, and Hornberger asserts: "Actually, none of us was into that. There were about a dozen nurses surrounded by thousands and thousands of horny males, including people in our own outfit. Some of the doctors scored heavily, but it wasn't really prime stuff. But the group in The Swamp did not get into that business." Kellum admits, "That stuff went on to some extent. Actually, the c. o. after Henry left married one of the female nurse anesthetists. There were relationships, hanky-panky, love affairs, going on. People would come from miles around just to see an American girl." But, Kellum too states that the Swampmen and Henry did not engage in such actions. Married during his time in Korea, Holleman watched the movie with his wife and after observing the character Blake's sexual exploits, explained to his wife that Hornberger based Blake on two commanding officers: "I was the fisherman, the other guy was the lover."

Not mentioned in the novel, movie, or series was a small "park" area at the MASH, garnished with green park benches and a few small shade trees. Also, there was no showering everyday for the MASH. "A shower unit came around once a week. The guys would shower in the morning, the ladies in the afternoon," says Holleman.

The MASH's femme fatale was Major Margaret "Hot Lips" Houlihan, the fortyish good looking Chief Nurse. "Our Chief Nurse was portrayed very much in character in the book. I won't tell you her name, but she was real," says Holleman, who adds that Hot Lips was a Texan. "She was the only one who didn't like her portrayal. She never came to any of the reunions," says Holleman. Kelluin states, "I understand one of the nurses was offended about the Hot

Lips business. I knew the nurse Hornberger had in mind, and I can't imagine her being offended." Another real character was the Catholic chaplain Father John Patrick Mulcahy, but he "wasn't nearly as active" in reality as portrayed in the novel, movie, and TV series, says Holleman.

Dominated by the specter of atomic holocaust, the war's fighting was of a limited scale. The battle lines soon stabilized around the 38th Parallel, and then began two years of military stalemate. This first war of the nuclear age strangely resembled an old fashioned war. Holleman compares the lack of front movement to "trench warfare" and adds, "Our forces would push theirs back a little bit then theirs would push ours back. It went on like that." Kellum remembers that each side was so well dug in that it "would have taken an A-bomb to move them." Although the MASH was never shelled, there were trenches behind the camp to get into if the Chinese ever rattled in. The Korean terrain, dotted by rice paddies and barbed wire, was hilly and mountainous, much like it is portrayed in the movie, and this made the fighting very difficult for the soldiers. "If Korea were flattened out," says Holleman, "it would be as big as the United States. The entire country is peaks and vallevs." This multinational police action ended inconclusively in July of 1953. After three years and more than two million casualties, the two sides stood on the barren landscape about where they had stood before the whole war started.

However, when orders came to return home, the MASH physicians were filled with both a great happiness to be going home and a great sadness to be leaving the group they had worked with so closely for a year. At the end of the novel, Hawkeye states, "When you live



The \$055 MASH: Looking down the tent row to "The Swamp".

in this sort of situation long enough, you either get to love a few people or to hate them, and we've been pretty lucky. I don't know. I do know that nothing like this will ever happen to us again. Never again, except in our families, will we ever be as close with anyone as we were in that goddamned tent for the past year...I'm glad it happened, and I'm some jeezely glad it's over." Of this ambivalence, Kellum states, "The day you walk into a place like Korea, you begin to scheme and plan how you're going to get the hell out of there and get home. But when the time comes, you've got all these friends you've been living with months to years. There is a sadness, but not enough that you would turn down those discharge papers." Holleman agrees, and notes that the reluctance he felt upon leaving centered on abandoning his friends and on going home "before the job was finished," for Holleman left the 8055 three months before Kellum and Hornberger.

#### HORNY WRITES MASH

While in Korea, Hornberger had no plans to write a novel, and he took no notes while serving there. "I began writing the novel as a hobby once I got back. I got out of Korea in 1953 and the book was published in 1968. That was quite a hiatus there." Hornberger had sent his fellow Swampman Kellum the manuscript of the novel several years before it was published. Kellum had edited his college newspaper (The Ranger at Northwest Mississippi Junior College) and Hornberger, who had also done some editing work in college, wanted some editorial advise. Kellum comments, "In the early 1960s, he sent me his manuscript. I read it and thought at the time that it was so outlandish. The main

reason he had sent it to me was to see whether or not I thought the portrayal of the Southern accent was legitimate." Although Kellum enjoyed the novel, he did advise Hornberger that his imitation of Southern verbiage was less than satisfactory and that changes needed to be made in Duke's language. Kellum states, [Hornberger] had used the expression 'you all' as a singular person. We never do that. I don't say to Hornberger 'Y'all come to see me' unless I'm talking about Hornberger and his wife." Despite this advance reading by Kellum, Hornberger either did not take Kellum's advise or misunderstood his criticism, for the author continued to use "y'all" in the singular in his book, a mistake he is not alone in making among non-Southern writers. Examples in the book can be found in many chapters, including the first chapter in which Duke, speaking only to Hawkeye, asks, "Who are y'all?" In his own defense, Hornberger relates, "I'm aware of Grip's gripe about 'y'all.' All I know is that when I go to pay for gas at a Southern gas station, the clerk in the store says 'how y'all today?' I look around and see no one else. Perhaps he/she means me and all my friends and neighbors, despite their absence."

Kellum contends that most of the stories Hornberger told in his novel were based on actual events, but were shaped and molded by Hornberger's dynamic imagination. "He's about two percent fact. He had a very vivid imagination and played mind games with himself all the time. For instance, he liked to have ice cubes in his afternoon highball. The only place we had a generator that ran a little refrigerator was tucked away in the dental lab tent. He would jog up there and get him some ice cubes and jog back. He would make like he was running a mile against Sebastian Coe or whoever the miler was at that time."

Kellum states that he can take any chapter in the book "and tell you exactly where Horny got his idea to spin off from and tell you where facts stop and fiction begins." For an example, he notes the famous football game at the novel's end, involving Spearchucker Jones. "We did play unserious touch football with a black quartermaster outfit across the road from us. Dickson got his skull fractured in one of those games. Some betting did take place. We gathered up about three grand and bet on a fight between Rocky Marciano and Jersey Joe Walcott. We won the money and that was where Horny got the idea for the outlandish bets and the big football game." Soon after publication in 1968, the book became a bestseller and went into multiple printings in both hardback and paperback.

## MASH GOES TO THE MOVIES AND TV

The movie M\*A\*S\*H (1970) was an innovative comedy produced by Robert Altman. Although about Korea, filming during the Vietnam War bestowed particular relevance to its theme of the madness of all wars. The absurdity of violence played effectively as geysers of blood spurt over operating rooms filled with doctors numbed by the everydayness of tragedy and violence and death. The witty adaptation of Hornberger's book won writer Ring Lardner, Jr., an Academy Award for best screenplay. "My only association with the movie was that I spent a weekend with Ring Lardner, Jr., who wrote the screenplay," says Hornberger. "I could not see any resemblance between the screenplay as he wrote



Entrance to the Receiving tent of the 8055th.

it and the movie. I never had anything to do with the movie beyond spending a little time with him." Hornberger relates that he did not help Lardner with any of the writing of the screenplay, he just spent a weekend with him, talking about Korea, the novel, and life, in general. "At that time," continues Hornberger, "I had a young family and a mortgage and I knew I wasn't a writer. I had to make a living doing surgery. I wasn't going to go run off to Hollywood. I had gall bladders and lungs to take out."

Lardner and Altman had done their homework on the real MASH unit, interviewing many of Hornberger's MASH friends, and using actual photos to construct the set and design the movie's clothing. Hornberger states, "I sent them some pictures and I imagine Dickson and the other guys did too." Kellum recounts that Hornberger had not intended as much anti-American and inti-war sentiment as portrayed in the movie, but taken as a whole, both Kellum and Hornberger thought the movie was "great."

M\*A\*S\*H the television series

began airing on CBS in 1972, while America was still mired in Vietnam. Like the movie's producers, the television series's producers Larry Gelbart and Gene Reynolds used their biting humor to provide commentary on the horrors of war, and perhaps more than the movie, its topics and issues were based more on the seventies and the Vietnam War than on the fifties and the Korean War. The UN effort in Korea did not elicit as noticeable an antiwar sentiment as did the US involvement in Vietnam. and this antiwar sentiment is the series's recurrent theme. Perhaps it is significant that the series was based on Lardner's screenplay rather than Hornberger's novel. Says Hornberger, [M\*A\*S\*H's television producers] never talked to me at all. I can not recall ever talking to anybody about the series." Soon after the book's publication, Hornberger had sold most of his creative rights and lost control of others's use of his MASH characters. "I got paid for the series. I got paid twice as much for a spin-off series called Trapper John, M. D. because it was an hour show and M\*A\*S\*H was just

a half-hour show. I don't get anything anymore. That ran out. You get something for 5 or 6 years after a series is discontinued. M\*A\*S\*H is still on in a lot of places, but I get nothing out of it."

By the third season, the halfhour television series was the first or second show in the ratings. This success led to a creative surge on the part of the producers, who attempted to push the limits of the traditional sitcom. The show chose controversial topics and unexpected storylines. The character Colonel Henry Blake, played by McLean Stevenson, was killed off by producers as a way to let Stevenson leave the series. The death surprised many watchers of the series, which satisfied the show's producers who were attempting to demonstrate the unpredictability of death. There were 255 episodes filmed before the series ended. The set of M\*A\*S\*H now resides at the Smithsonian Institution, as part of the National Museum of American History.

Although Hornberger enjoyed the movie translation of his novel, he expresses great dissatisfaction with the television series, "I loved the movie, but I couldn't stand the television series. I didn't like it at all. I couldn't stand the dialogue. I particularly couldn't stand Alan Alda playing Hawkeye." Alda had infused Hawkeye's irreverent sarcasm and wit with a liberal political slant, and the more conservative Hornberger did not appreciate this feature. Chief among his complaints, however, is Duke's disappearance as a character on the series. Hornberger, "I have no idea why Duke was dropped. They didn't consult me about it. They dropped Spearchucker for obvious reasons. I think that there were just so many characters they could bridle and of course they created some of their own who were not as useful as Duke would have been. All these [television producers] are doing is trying to sell cars or beer. I have no idea what their thinking was, if they even thought at all."

Kellum himself laments the loss of Duke in the television series: "They dropped the Southern guy because Southerners don't sell shaving lotion to all segments of the population." Holleman agrees, "In the racial consciousness of the early 1970s, Duke wouldn't fit in the social structure of the television series." The television writers contacted Kellum for program ideas, but he states he never did respond to them. Like Hornberger, Kellum seldom watched the television series, detesting its corruption of the novel's original characters. "I didn't like Alan Alda. He sounded like a duck. I didn't like the crossdresser either. That was a little too far out," comments Kellum.

Holleman too shares his friends' preference for the "original movie," although he appreciates McLean Stevenson's portrayal of Colonel Blake on the television series. Says Holleman, "I've looked at the movie at least a dozen times, and each time I look at it I see something I missed the first time I saw it." He enjoyed Roger Bowen's movie performance as the MASH commanding officer, especially the fishing interest, but states that Bowen "was kind of wishy-washy in the movie. He kind of let those guys run his business," which Holleman maintains was not like the real situation in Korea.

#### THE MASH REUNIONS

The 8055 MASH had a reunion in Evansville, Indiana in 1972. It was hosted by the unit's anesthesiologist (Dale Drake). "About nineteen Radars showed up," laughs Kellum. In the summer of 1989,

several members of the 8055 gathered at Jackson's Millsaps College to honor their commanding officer Holleman, who was celebrating the fiftieth anniversary of his Millsaps graduation. "Several of us came down and gave talks," says Hornberger. Members of the old 8055 keep in touch with one another. "Over the years," says Hornberger, "I've seen a lot of Trapper John and almost as much of Grip Kellum and Jerry Holleman." Hornberger's last visit to Mississippi was in March of 1991, and Kellum writes that Hornberger "made a quick golfing tour of the state and visited several Civil War battle sites, Vicksburg and Shiloh," where field tent hospitals had been utilized more than 100 years earlier.

The book has lapsed out of print and Hornberger presently receives no income from book sales. He states, "I have no income from the book. I wouldn't know where even to find a copy of it." His own life is now far less hectic than his MASH days in Korea. "I just work five or six mornings a month examining supplicants for Social Security disability. I play golf and don't do much of anything else," he says. These days, he feels little pressure to write. "Nobody will buy anything I write anymore," he says, "After MASH, I wrote a couple of books. One was called MASH Goes to Maine. There was one they decided to call MASH Mania, which never did anything. Then there were 13 ghost written books such as MASH Goes to New Orleans. I didn't even read them. I got paid for them, but they didn't pay me enough to read them." However, he and his MASH friends Grip Kellum and Henry Holleman remain close, visiting one another and exchanging letters and phone calls. Says Hornberger, "the friendships I made in Korea were worth the ordeal." Holleman asserts that their Korean experience was a "wonderful learning experience in many ways, not only in surgical techniques and surgical procedures, but of how to deal with different people." Despite the overwhelming depiction of the horror of war, the novel MASH is a tribute to the triumph of friendship, a tribute to a group of physicians, of different backgrounds and interests, who were brought together in a time of crisis and remained forever friends.

#### Acknowledgements

The author would like to thank Drs. Richard Hornberger, Grip Kellum, and Henry Holleman for their assistance with this article, which included interviews with each of them and the loaning of photographs. As well, the author expresses his appreciation to Dr. and Mrs. Ramon Lott of Columbus, Mississippi, Lt. T. Dudley Lampton of Morgan City, Louisiana, Dr. Ilya Stone of Little Rock, Arkansas, and my parents Dr. and Mrs. T. D. (Bob) Lampton of Jackson, Mississippi for their encouragement and assistance.

Lucius "Luke" Lampton, MD is presently doing his residency in the Department of Family Medicine at Jackson's University Hospital. Lampton was 1992-93 Editor of The Murmur, the University of Mississippi School of Medicine newspaper. He was also a winner of the 1993 William Carlos Williams Poetry Competition and a contributor of several signed entries to the recently published Mark Twain Encyclopedia.

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The President's Page DON Q. MITCHELL, MD

## Row, Row, .....

The health-system reform debate is heating up on the national front as congressional committees hold hearings on reform proposals. The President's plan seems to be losing ground while other compromise plans seem to be gaining. I'm often asked "What is going to happen?" My belief is that the first product will likely be drawn from several different proposals and will focus initially on expanding access to coverage for individuals and small employers, insurance reforms (portability and limits on pre-existing disease), controlling costs and measuring quality.

Although these changes will be viewed as something less than total health system reform, these things will provide a foundation for further change and tinkering for years to come.

Regardless of what Congress does with the issue of health system reform, the system is still going to undergo some very significant changes. Although not as far along as most other states, we are witnessing some of these changes in Mississippi with the increased emergence of managed care. These changes are not being driven by government edict, but rather by competitive market forces.

Obviously at this point we don't know the extent to which government, either state or federal, will ultimately control the health delivery system. But we believe that the real battle for managed care decision authority is going to be among doctors, hospitals and insurance companies.

As physicians we have a choice. We can turn this issue over to the large insurance companies and vertically-integrated health delivery systems or we can recognize the real

(Continued on page 80)

## **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 3 MARCH 1994

## **Respected Colleagues**

This past Sunday evening, as I was relaxing after a refreshing and rejuvenating weekend off-call from the stress and strain of medical practice, the phone rang. As expected, the doctor on-call for our family practice group was signing in after a strenuous weekend of hospital rounds, phone calls, and office and ER visits. My associate was surprisingly cheerful as he reviewed the list of hospital admissions and discharges. I was impressed not only by the professional and thorough manner in which this task was handled by him, but also by the caring manner projected toward the patients for which he was responsible during the weekend. After some reflection, I realized that this was not an unusual occurrence, but only the first time that I had appreciated its significance. I cannot judge myself as a physician, but I can tell you that my practice associates, and, I suspect, most of our colleagues, provide exemplary care for their patients.

To take for granted the superior training, professionalism, and caring attitude of the overwhelming majority of physicians is easy, because it is the rule, not the exception, in our present system of care. To imagine a health care system devoid of that training,

professionalism, and caring is frightening. As the health care reform debate takes shape, the American people would be well advised to consider seriously and realistically what our system of care would be like without the dedicated physician as "captain of the ship." When the chips are down, I don't believe such a prospect would be very popular, and we, as physicians to whom our patients look for guidance, need to redouble our efforts to ensure, if humanly possible, that such a tragedy does not occur.

Make no mistake about it, no health care system devised by human hands will be perfect. Someone or something will always "slip through the cracks." Doesn't it make sense, then, to promote a system which preserves the individual's right to choose, and which preserves the physician-patient relationship? Of course it does. Can we afford such a system? Certainly. Can we afford not to have such a system? I think not.

George E. Abraham, II, MD Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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President's Page (Continued from page 78)

power that we have through the actual delivery of care and legally organize ourselves in such a way that will permit us to exercise the real decision making authority in delivering care in a managed care market place.

As you are aware, we have organized the Mississippi Physicians Care Network (MPCN), a statewide PPO that will contract with employers who have self-funded health benefit plans for their employees, which includes roughly 60% of the employers in the state.

The MPCN will provide cost-effective, high quality care and be at partial risk with these contracted employers in managing the cost of care provided to their covered employees.

MPCN will be the <u>only</u> statewide, physician-driven and controlled managed care organization operating in Mississippi. At present, over 1000 physicians have joined the network.

We are currently working with our managed care consultants to position the Network to be a principal player in competing for the business of health coverage purchasers in whatever system of health care reform that is ultimately enacted.

As you go about deciding whether or not to participate, I urge you to consider what I believe is the most crucial issue for our profession..... Who should control the delivery of care to our patients?

I hope you will answer that question by sending in your application to participate in MPCN today, which would mean you believe as I do — that we physicians have an obligation **not** to turn over control of delivery of care for our patients.

The choice is ours. Let's row out to meet the ship of health system reform and guide it through turbulent waters and <u>not</u> sit on the shore.

Your Colleague,





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## Take Care Project Targets At-Risk Population

Leigh H. Grady, BS, MBA Jeanne B. Luckett, BA

Teenage pregnancy, inadequate prenatal care, low birthweight, and infant mortality are continuing problems in the State of Mississippi. According to the July 1993 Health Futures County Data Book, our state has the highest rates of births to adolescents and low-birthweigh babies in the nation. One in four pregnant women in Mississippi does not obtain prenatal care until the fourth month of pregnancy or later.

Consequently, although we have made progress, we remain near the bottom in infant mortality rankings. Our rate for 1992, 11.9 deaths per 1,000 live births, is actually a slight increase over 1991, while other states in our region are showing decreases.

In order to help reverse these trends and their economic and social impact, the Mississippi State Department of Health has initiated a multifaceted campaign of education and awareness with a special emphasis on prevention of adolescent pregnancy. The Take Care Project, funded by a Healthy Futures grant from the Robert Wood Johnson Foundation, is being developed by Communication Arts Company, a Jackson design and production studio. Some aspects of the project will have statewide dissemination. Eighteen counties with the highest adverse outcomes and percentages of at-risk populations are targeted for special initiatives.

Market research has been conducted with the target consumer population, adolescents ages 11-18 as well as pregnant women, to have a better understanding of their behavior, the information they need to know, and the best means of reaching them. Primary care physicians and public health employees were also sur-

veyed. They stressed the need to educate the population about the importance of prenatal care and family planning. They also was a need to remind new patients to practice compliance with instructions and to keep appointments. Based on the data collected, outreach education materials are being developed. Emphasis is being placed on delaying adolescent sexual activity, encouraging the use of family planning services, and encouraging pregnant women to seek early and regular prenatal care. Medicaid eligibility determination and enrollment are also promoted.

An important like in the communications chain is a statewide toll-free perinatal telephone line for consumers. The Take Care phone number is 1-800-721-7222 and will be included on all educational materials developed.

Other public awareness materials designed for the general public and the legislature will be disseminated. Local projects involving schools, churches, volunteer groups, and businesses are being developed in each of the target counties.

For more information contact Jeanne Luckett or Leigh Grady with Communication Arts Company at 354-7955; Charlotte Smith, Perinatal Services, Mississippi State Department of Health, 960-7758; or Nancy Kay Sullivan, Health Communications and Public Relations, Mississippi State Department of Health, 960-7667.

Leigh Grady is Project Coordinator, and Jeanne Luckett is Executive Director of the Take Care Project.

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## MISSISSIPPI STATE MEDICAL ASSOCIATION

## **Membership Benefits**

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

#### MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about programs and policies of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

#### LIAISON SERVICES

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

#### **HEALTH INSURANCE**

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

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The MS Physicians Insurance Company (MPIC) in cooperation with MSMA offers a wide range of insurance for members of the association. MPIC has a Board of Directors appointed by MSMA composed entirely of practicing physicians who seek to identify the special insurance needs of physicians. For further information contact Jennifer Jones at MPIC.

#### PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workships for physician's office personnel. These workships pover a mad range of topics from CPT-IV coding to patient surver for further information call Jackye Wiebelt at MANA Inversified Services, Inc.

#### DEBT COLLECTION SERVICE

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call Robert Kidd at MSMA.

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The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. More than 1700 Mississippi physicians are currently insured by MACM and extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Advisers - 200 N. LaSalle Street, #535, Chicago, IL 60601, 800-525-0864.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In -State-WATS).

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When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

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## **Medical Organization**

## River Oaks Hospital Selects 1994 Executive Committee



Recently, the Medical Staff of River Oaks Hospital selected its 1994 Executive Committee. Shown in the above picture are the committee's officers and members.

First row, from left to right: Mickey Wallace, MD, member-atlarge; Cindy Haden-Wright, MD, secretary; Beverly McMillian, MD, member-at-large; John Wofford, MD, vice chief of staff; and Brooks Griffin, MD, chief of staff.

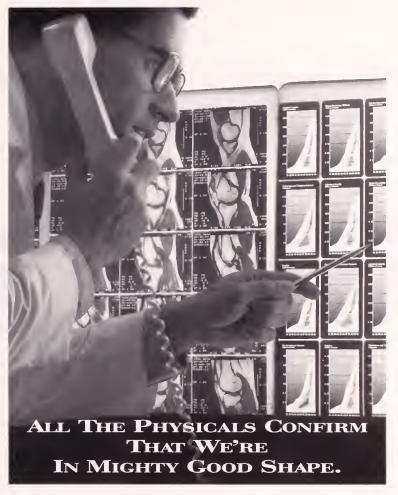
Second row, from left to right: Barry McCay, MD, member-at-large; Phillip Blevins, MD, member-at-large; Orin Guidry, MD, chairman, anesthesia service; Gary Nowell, MD, member-at-large; and Reginald Rigsby, MD, member-at-large.

Members of the Executive Committee not pictured are: Cindy Allen, MD, chief of

medicine; David Gandy, MD, member-at-large; Lee Sams, MD, past chief of staff; and George Shaak, MD, chief of surgery.







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#### **New Members**

Acosta, Joseph R., Greenwood. Born Topeka, KS, April 20, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; ob-gyn residency, University of Tennessee, Chattanooga, TN, 1989-1993; elected by Delta Medical Society.

Andy, Orlando J., Jr., Hattiesburg. Born Jackson, MS, August 11, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; general surgery residency, University Medical Center, Jackson, MS, 1988-93; elected by South Mississippi Medical Society.

Armstrong, George W., III, Coffeeville. Born October 10, 1935; MD, University of Tennessee School of Medicine, Memphis, TN, 1964; internal medicine residency, Presbyterian Hospital, Denver, CO, 1965 - 68; elected by North Mississippi Medical Society.

Boleware, Edwin G., Vicksburg. Born Willits, CA, November 28, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; internal medicine residency, University Medical Center, Jackson, MS, 1988-1991; gastroenterology fellowship, same, 1991-1993; elected by West Mississippi Medical Society.

Busch, Lance E., Columbus. Born Perth Amboy, NJ, November 13, 1956; DO, University of Medicine & Dentistry of New Jersey, 1983; one year internship, Cleveland, OH; medicine residency, Rutgers Medical School Affiliates, NJ; fellowship pulmonary medicine and critical care, Baylor College of Medicine, Dallas, TX.; elected by Prairie Medical Society.

Gaymes, Charles H., Jackson. Born Aruba, NA, September 21, 1952; MD, University of the West Indies, Mona, Kingston, Jamaica, 1978; interned one year, University Medical Center, Jackson, MS, 1986-87; pediatric residency, same, 1987-89; fellowship in pediatric cardiology, Medical University of South Carolina, Charleston, SC, 1989-92; elected by Central Medical Society.

Gulce, John M., Meridian. Born Laurel, MS, October 9, 1960; MD, University of Mississippi School of

Medicine, Jackson, MS, 1986; surgery residency, Div. Urology, Medical College of Virginia, Richmond, VA, 1986-92; elected by East Mississippi Medical Society.

Patel, Bharti, Jackson. Born Valam, India, April 26, 1951; MD, Govt. Medical College India, 1975; anesthesia residency, Albany Medical Center, Albany, NY, 7/80 - 6/82; elected by Central Medical Society.

Puricelli, Mark S., Hattiesburg. Born St. Louis, MO, June 1, 1961; DO, University of Health Sciences of Kansas City, MO, 1988; one year internship, Nomandy Osteopathic Hospital; Neurology

residency, St. Louis, University School of Medicine Hospital, St. Louis, MO, 1989-93; elected by South Mississippi Medical Society.

Rusch, James A., Gulfport. Born New Orleans, LA, June 25, 1957; MD, Louisiana State University School of Medicine, New Orleans, LA, 1983; surgery residency, one year, Hermann Hospital, Houston, TX; psychiatry residency, Tulane University School of Medicine, New Orleans, LA, 1986-89; elected by Coast Counties Medical Society.

Smoot, John M., Batesville. Born Brownsville, TN, January 2, 1950; MD, University of Tennessee School of Medicine, Memphis, TN, 1975; one year internship, Baptist Memorial Hospital, Memphis, TN; one year family practice residency, same, 1977-78; elected by North Mississippi Medical Society.

Terral, T. Gregory, Jackson. Born New Orleans, LA, November 25, 1961; MD, Louisiana State University School of Medicine, New Orleans, LA, 1987; orthopedic surgery residency, University Medical Center, Jackson, MS, 1988-92; one year fellowship, Institute for Bone & Joint Disorders, Phoenix, AZ; elected by Central Medical Society.

Vohra, Rahul, Jackson. Born New Delhi, India, Sept. 19, 1964; MD, Baylor College of Medicine, Houston, TX, 1989; physical medicine & rehabilitation residency, same, 1989-93; elected by Central Medical Society.

#### New Members / continued

Vanderloo, Thomas E., Columbia. Born August 30, 1939; MD, Georgetown Medical School, Washington, DC, 1965; one year internship, Mercy Hospital, Pittsburgh, PA; elected by South Mississippi Medical Society.

Wasserman, John M., Biloxi. Born Toledo, OH, August 3, 1941; MD, St. Louis University School of Medicine, St. Louis, MO, 1967; interned one year Wright-Patterson AFB, Dayton, OH; psychiatry residency, Wilford Hall, USAF Medical Center, San Antonio,TX, 1968-71; elected by Coast Counties Medical Society.

Westbrook, Herman Wade, Southaven. Born Columbus, MS, February 17, 1941; MD, University of Tennessee School of Medicine, Memphis, TN, 1971; ob-gyn residency, City of Memphis Hospitals, Memphis, TN, 1972-75; elected by Desoto County Medical Society.

Winkelmann, Michael H., Jackson., Born Cologne, Germany, September 11, 1955; MD, University of Vienna, Vienna, Austria, 1987; internal medicine residency, University Medical Center, Jackson, MS, 1987-90; physical medicine & rehabilitation fellowship, Baylor College of Medicine, Houston, TX, 1990-93; elected by Central Medical Society.

#### **Deaths**

Hurst, Marlon F., Meridian Born Henderson, TN, October 14, 1938; MD, Darversity of Tennessee College of Medicine, Memphil FN, 1963; interned one year Pensacola Hospital, Pensacola H; radiology residency, Ohio State University College of Medicine, Columbus OH, 1965-68; member of East Mississippi Medical Society; died November 20, 193, age 55.

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

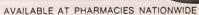
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.  $^{1.3.4}$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $\frac{1}{2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.  $^3$ 

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#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
- 4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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#### **Personals**

Stanley Hartness of Kosciusko was recently appointed to the Committee on Bylaws of the American Academy of Family Physicians.

F. Lee Horn announces the opening of office for family practice at the Medical Plaza, 1002 E. Madison, Houston.

Douglas Leonovicz has associated with Alton H. Dauterive for the practice of peripheral vascular surgery, Gulf Health Specialist Building, 1110 Broad Avenue, Suite 400, Gulfport.

Aubrey B. Lucas of Jackson announces the relocation of his office to 1020 River Oaks Drive, Suite 480, Jackson.

Gordon H. Meador of Tupelo announces his reassociation with North Mississippi Pediatrics for the practice of pediatrics, 5 Medical Park Circle, Tupelo.

**David A Pomierski** of Meridian was recently named a Diplomate of the American Board of Orthopedic Surgery.

J. Ed Ruff, II, of Jackson announces his retirement from the private practice of psychiatry in Jackson and his relocation to the Gulfport VA Psychiatric Hospital for the full-time practice of psychiatry.

F. H. (Buddy) Savoie was lecturer at the Current Concepts of Should & Elbow Surgery Lecture & Workshop held in St. Petersburg, Florida, where he spoke on Arthroscopy of the Elbow and Management of Arthrofibrosis & Ankylosis of the Elbow. He was also an instructor of Shoulder & Elbow Arthroscopy, Shoulder Instability Repair, Shoulder & Elbow Replacement, and Tumor Resection at the workshop.

Ellzabeth Hurst Smith announces the opening of her practice in Radiation Oncology at Regional Cancer Center, Pascagoula. Plez Tinsley, Jr, of Meridian, has been named a diplomate of the American Board of Facial Plastic and Reconstructive Surgery Inc.

Thomas E. Vanderloo, of Columbia was recently recertified by the American Academy of Family Physicians.

Paul W. Warrington of Cleveland has been recertified a diplomate of the American Board of Family Practice.



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CENTRAL MEDICAL SOCIETY
Charles Hartwell Williams, MD

North Central Medical Society Rebecca Hodges, MD

Northeast Mississippi Medical Society

David Walden Bell, MD

Sing ing River Medical Society Elizabeth Hurst Smith, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

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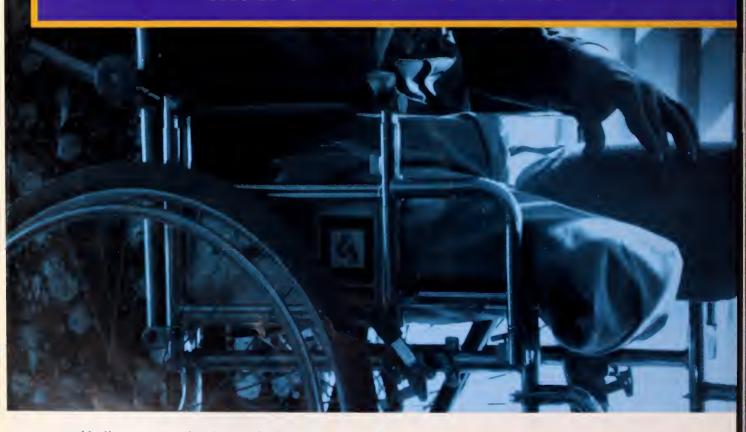
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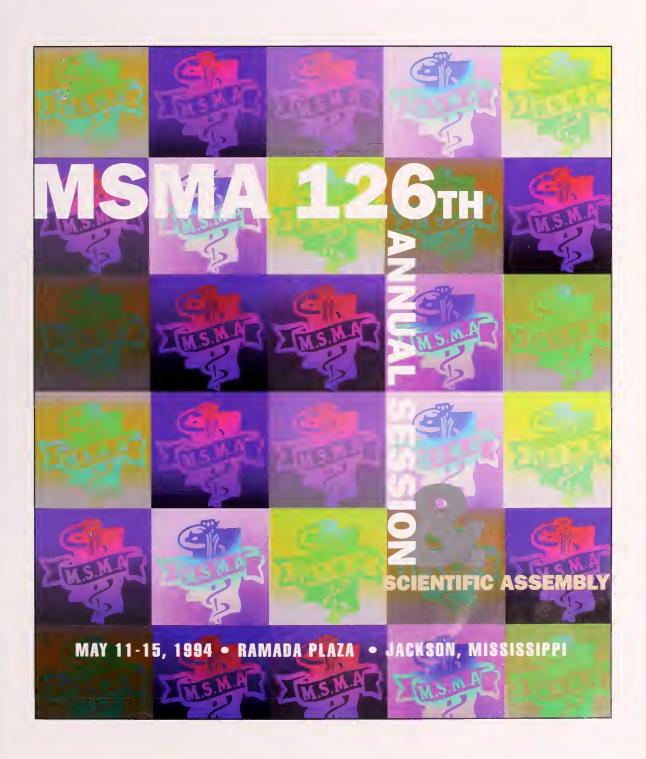


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# OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

APRIL 1994



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# JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

**APRIL 1994** 

**VOLUME XXXV** 

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Charles L. Mathews
Executive Director

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#### **Dateline**

### Journal of the Mississippi State Medical Association Volume XXXV, Number 4

### 126th Annual Session Scientific Exhibits

The MSMA 126th Annual Session will be held May 11-15, 1994 at the Ramada Plaza Hotel, 1001 E. County Line Road, Jackson, MS. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or Fax the following information to (601)352-4834.

#### The request for exhibit space should include:

- (1) the title of the exhibit;
- (2) the author(s) of the exhibit;
- (3) an estimate of the amount of exhibit space needed (MSMA will provide a table only all other materials are the responsibility of the exhibitor); and
- (4) a brief synopsis of the subject to be exhibited.

\* \* \*

## Cancer Registry Could Help Identify Diseases

Jackson — A new statewide cancer registry will help physicians identify and investigate a disease that has claimed the lives of thousands of Mississippians, health officials say.

The registry, made possible through a \$124,193 allocation from the 1993 Legislature, will collect information from hospitals. "This will be a move in the right direction. And possibly a move toward the eventual development of a statewide cancer center, a center focused not on treatment, but on research," said Dr. Tate Thigpen, the University of Mississippi Medical Center's director of oncology.

"It would give us more information - a better read on the health needs of the state, " Dr. Thigpen said. "We could set our priorities right, and it could make us more competitive for federal grants our state needs."

Dr. Mary Currier, state epidemiologist, said she expects funding for the registry to arrive during the current fiscal year, which ends June 30.

"It will help us identify and investigate reported clusters of cancer cases we are told of," Dr. Currier said of the registry. "And we can begin immediate, wide-sweeping intervention strategies and educational and prevention programs."

(continued)

Cancer Registry - continued Health officials said hospitals now organize cancer records differently and a statewide registry will help establish a uniform system that will be beneficial in research.

Breast cancer is consistently in the top five cancers logged in hospital tumor registries around the state. Those registries rank the types of cancer Mississippians contract most often.

Bruce Bracken, state deputy epidemiologist, said the state's cancer figures reflect the national trend. In order of highest incidence, they are lung, breast, prostate, colon/rectal and cervical cancer.

The National Cancer Research Institute estimates that in 1994 Mississippi will see 2,500 men diagnosed with prostate cancer, 2,100 people diagnosed with lung cancer, and 1,700 people diagnosed with breast cancer.

Total new cancer cases in Mississippi for 1994 could be 13,200 the institute says.

Having concrete cancer figures specific to Mississippi is "one of the greatest advantages" of a statewide registry, said Debbie Christie, director of cancer research and education support services at UMC. "This would be great, especially when we see areas where there are high rates."

Hospital tumor registries reflect slightly different trends from year to year. For example, as prostate cancer screening blood tests have become more popular, the number of diagnoses of the disease has escalated strikingly, say tumor registry directors.

\* \* \*

Most Elderly Drivers Not Denied Licenses

Jackson, MS — When elderly Mississippians show up at one of the 80 drivers license testing centers around the state, chances are they will not be questioned.

License renewals often are granted wholesale, Department of Public Safety Officials said, because of staffing restraints and weak state law dealing with license testing.

To renew a license, Mississippians must pay the \$20 fee and have their pictures made every four years.

Some states, such as Louisiana and Georgia, require eye tests.

Mississippi law allows, but does not require, Public Safety officials to deny licenses to drivers who have a physical or mental disability.

"It puts the department in kind of a sticky situation because we don't have a law that backs us up," said Capt. Wayne Parker, who oversees licensing.

"Our examiners in the field are told if someone comes in and it's obvious (they're incompetent,) they can re-examine them.

\* \* \*

#### The Hospital Medical Staff Section 23rd Assembly Meeting June 9-13, 1994 Chicago Marriott Hotel Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

Success will depend on unified physician support and action. Mark your calendar and plan to attend!

For more information please call 312 464-4754 or 464-4761



## MISSISSIPPI: WHO'S STAFFING OUR EMERGENCY DEPARTMENTS?

Robert C. Forbes, MD Bryce R. Turnage, M2

mergency services in our state have come under scrutiny over the past few years with CO-BRA\* legislation and tension over the issue of unreferred call. As part of a summer research project, we chose to survey the emergency departments (EDs) in our state to determine the characteristics of the physicians providing this important service.

#### **METHODS**

We obtained a list of hospitals reporting emergency departments for the year 1992 from the State Department of Health. Eighty-eight hospitals with emergency departments were selected after excluding three which were not available to the general public. We arbitrarily chose four times during one week (10 a.m. and 10 p.m. on Tuesday and Saturday). Using a questionnaire, we determined, for each of the four times, whether or not a physician was present in the ED, their specialty, board certification, whether they were from the community and whether they were a resident-in-training. We contacted all 88 emergency departments. Hospital EDs were divided into three

Emergency services in Mississippi have come under scrutiny over the past few years. As part of a summer research project, we surveyed all 88 Mississippi emergency departments available to the public to determine physician staffing characteristics. At four times during one week (10 a.m. and 10 p.m. on a Tuesday and a Saturday), we determined whether a physician was present, their specialty, board certification/resident status, and whether they were from the community. Our paper presents and discusses the findings.

groups depending on the number of reported visits per year: those with less than 10,000, between 10,000 and 20,000, and more than 20,000 numbering 46, 27 and 15, respectively.

<sup>\*</sup> Consolidated Omnibus Budget Reconciliation Act of 1985

TABLE 1. S	TAFFING PA	ATTE	RNS	OF M	issi	SIPP	I EM	ERGE	NCY	DEP	ARTMEI	NTS	BY V	ISI:	rs/YE	\R		numk	pers	(per	cent	*)			
Hospital visits/year < 10,000							10-20,000 > 20,000																		
Number of h	ospitals				4	6							2	7							1	5			
Day/time		TUE	am	TUE	pm :	SAT	am	SAT	pm	TUI	am :	TUE	pm	SA	r am	SAT	pm	TUE	E am	TUE	pm	SAT	am	SA:	r pu
Physician?	Yes	10	(22)	28	(61)	37	(80)	40	(87)	26	(96)	27 (	100)	27	(100)	27 (	100)	15 (	(100)	15 (	100)	15 (	100)	15	(100)
Specialty?	EM FM/GP IM	5	(20) (50) (20)		(7) (68) (11)	3 25 5	(8) (68)	1 28 3	(3) (70)	11	(15) (42)	10	(15) (37)	4 12 5	(15)	11	(18) (41)	13	(87)	1	(80) (13)	13	(86) (7)	12 2	(80) (13)
	SURG PED OTHER		(10)		(11)	3	(13) (8) (3)	1 -	(7) (13)	1	(35) (4) (4)	1 2	(26) (4) (7) (11)	1 3 2	(19) (4) (11) (7)	2 1 1	(26) (7) (4) (4)		(13)	1	(7)	1	(7)	1	(7)
Boarded?	Yes	7	(70)		(46)	15	(40)	_	(42)	_		-				15	(55)	13	(87)		(60)		(86)	10	(67)
Local?	Yes	4	(40)	13	(46)	16	(43)	18	(45)	11	(42)	12	(44)	11	(41)	14	(52)	13	(87)	14	(93)	9	(60)	13	(87)
Resident?	Yes			4	(14)	2	(6)	4	(10)	1	(4)	4	(15)	4	(15)	4	(15)	1	(7)					1	(7)

percentages approximate

TABLE 2. STAFFING PATTERNS OF MISSISSIPPI EMERGENCY DEPARTMENTS numbers (percent*)											
Number of hospitals 88 (ALL)											
Day/time		TUE	am	TUE	pm	SAI	am	SAI	. pm		
Physician?	Yes	51	(58)	70	(80)	79	(90)	82	(93)		
Specialty?	EM FM/GP IM	19 16 13	(37) (31) (26)	18 31 10	(26) (44) (14)	20 38 10	(25) (48) (13)	18 41 10	(22) (50) (12)		
	SURG PED OTHER	2	(4)	4	(6) (10)	4 4 3	(5) (5) (4)	8 2 3	(10) (2) (4)		
Boarded?	Yes	34	(66)	42	(60)	44	(56)	42	(51)		
Local?	Yes	28	(55)	39	(55)	36	(45)	45	(55)		
Resident?	Yes	2	(4)	8	(11)	6	(8)	9	(11)		

<sup>\*</sup> percentages approximate

#### RESULTS

A summary of the results are shown in Table 1 and Table 2. Only twenty-two percent of the smaller EDs had a physician present on Tuesday morning, but the percentage increased to 87 percent on Saturday night. Essentially 100 percent of the larger EDs had a physician present at all times. Emergency medicine physicians staffed the 15 larger EDs most of the time, while family physician/general practitioners provided the major coverage of the medium and smaller EDs. Board certification varied from 45 to 67 percent, with a higher percent in the large EDs. Approximately half of the physicians covering the smaller and medium-sized EDs were from the community while a greater number (60-93%) of the larger FDs were staffed by local physicians. Residents tended to cover at night or on the weekend.

#### DISCUSSION

The results confirm that family physicians play a major role in covering our emergency departments. Coverage by emergency medicine physicians was concentrated in the few larger hospitals and communities. Family physician staffing was most prevalent in the small and medium-visit hospitals, although local physicians appear to be utilized less than we expected. Resident coverage is also less than anticipated.

A 1987 survey reported 108 EDs serving a Mississippi population of 2.6 million. This contrasts with our total of 88 EDs for approximately the same population. In 1990, 31 percent of Connecticut EDs were staffed by physicians stating their specialty as emergency medicine. Similar surveys in other states would be simple and would help further determine manpower needs in this critical area of patient care.

2500 North State Street Jackson, MS 39216

This research was supported in part by DHS Predoctoral Training Grant in Family Medicine # ID15 PE84050 03.

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- 3. Salluzzo R, Terranova G, Gemmell W, Boland B. Connecticut emergency department physicians survey. Nebraska MJ 1990;54(1):3,4.
- Dr. Forbes is assistant professor of family medicine in the Department of Family Medicine and Mr. Turnage is a 2nd year medical student both at the University of Mississippi Medical Center, Jackson.

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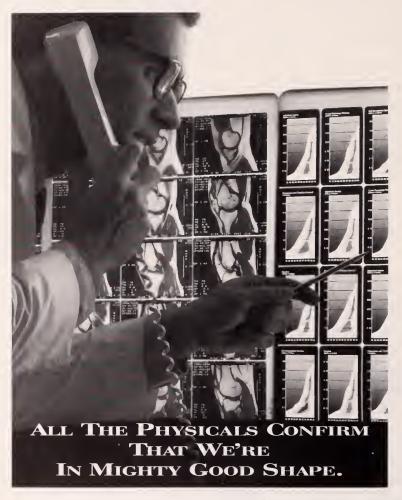
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#### 126th Annual Session May 11-15, 1994 Ramada Plaza Hotel Jackson, MS

## OFFICIAL CALL To: All Members of the Mississippi State Medical Association

The 126th Annual Session of the Mississippi State Medical Association is called to meet in Biloxi, Mississippi on Wednesday, May 12, 1994, pursuant to Article V of the Constitution.

The House of Delegates will be convened at the Ramada Plaza Hotel at 9:00 a.m. on May 12. The Scientific Assembly will meet May 13 and 14.

No member or guest will be permitted to participate in any aspect of the Annual Session until regularly registered.

Don Q. Mitchell, MD, President D. Stanley Hartness, MD, Secretary-Treasurer

#### 126th Annual Session Ramada Plaza Hotel, Jackson

MSMA's 126th Annual Session will be held at the Ramada Plaza Hotel in Jackson, Mississippi, Wednesday, May 11 - Sunday, May 15. Individual room reservations should be made directly with the Ramada Plaza prior to April 26. A room registration form was enclosed in the March MSMA Report.

The annual President's Reception will begin, Thursday, May 12 at 6:30 PM at the Mississippi Agricultural and Forestry Museum in the Forestry Auditorium. Association members and guests will enjoying fiddling music, and drinks in the country western style while touring the museum grounds. Carousel and hayrides will be available for children from 6:30 to 7:30 PM. A Catfish dinner will be served at 7:30 PM followed by the evening entertainment. The Capi-

tal City Chasers will be showing off their dancing style backed by the music of Ghost Town from Brookhaven, MS. Wear your western duds and learn to line dance before the evening ends. The MSMA President's Reception is sponsored by Trustmark National Bank, Canton.

The MSMA/MSMA Alliance Membership Party will be held, Saturday, May 14, at 7:00 PM in the Grand Ballroom of the Ramada Plaza. The party this year will honor Dr. Norman C. Nelson, vice chancellor, for health affairs and dean of the School of Medicine, who plans to retire in August, 1994. Members and guest will have the opportunity to visit with Dr. and Mrs. Nelson during the party.

The MSMA Alliance will once again hold a silent auction with proceeds benefiting AMA-ERF. Association members and guest will be able to browse through the items for auction

and make their silent bid during the party. Auction items will be displayed in meeting room B, Thursday, May 12 until the auction on Saturday May 14. There will also be other special fun fund raising activities during the party.

Music for the evening will be provided by the "Gators", a group well known to many of our association members.

#### **House of Delegates**

The opening session of the House of Delegates will convene on Thursday, May 12, at 9:00 AM in Meeting Room C. Speaker of the House Dr. Vann Craig of Natchez requests that all delegates be certified and in place by 9:00 AM.

Delegates will hear an address by Dr. Robert E. McAfee, president-elect of the American Medical Association. Dr. Don Q. Mitchell, MSMA president will also address the House.

Reports and resolutions will be introduced at the initial meeting of the House for consideration by Reference Committees which will meet on Thursday afternoon. Please note that all reference committees will meet on Thursday afternoon. Reference Committee A will meet in Seminar rooms I & II immediately following the Reference Committee on Constitution and Bylaws. Reference Committee B will meet in Meeting room C.

The MSMA 1994 Community Service and other special awards will be presented during the opening session.

Delegates will reconvene on Sunday morning, May 15, to take action on policy recommendations and to elect MSMA officers for 1994-95. The installation of Dr. Mallan G. Morgan, of Natchez as MSMA 1994-95 president will mark the official conclusion of the 126th Annual Session.

## Residents and Medical Students Meeting

Dr. Robert E. McAfee, AMA president-elect will meet with residents and medical students

at the University of Mississippi Medical Center in Room-354. During this informal question and answer session Dr. McAfee will talk with residents and students about their future in medicine. This session will be held on Thursday, May 12 at noon. Residents and students are invited to bring their lunch and eat during the session. A special drawing will be held for those present.

#### **Educational Programs**

Educational sessions are scheduled for Friday, May 13 and Saturday, May 14. Both sessions will address the current issues in Health System Reform. Members are encouraged to attend both sessions. The Council on Scientific Assembly designates this continuing medical education activity for 6.5 hours of Category 1 of the Physicians Recognition Award of the American Medical Association. The CME certificate is located on the back page of the 126th Annual Session program.

#### **Technical Exhibits**

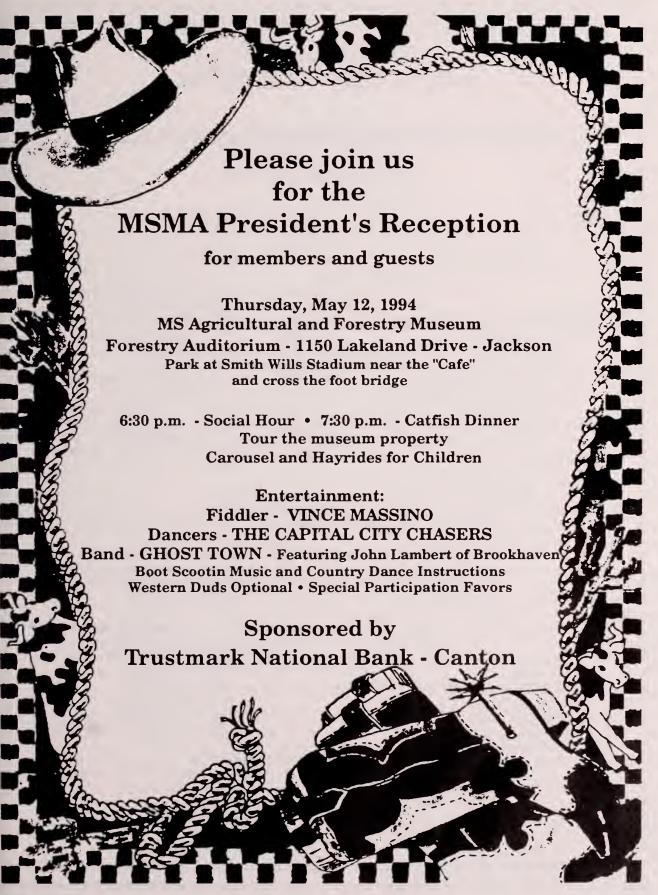
The Technical Exhibit features 40 displays of the latest in resources for physicians. The program includes two continental breakfasts and one luncheon in the exhibit area. This was planned to provide MSMA members with additional opportunities to view the exhibits and talk with the professional representatives who will be available to provide information. Members are eligible for numerous exhibit registration awards.

#### **MSMA Alliance**

The MSMA Alliance will be conducting their 71th Annual Session during the week at the Country Club of Jackson.

MSMA and MSMA Alliance members will again have the opportunity to enjoy coffee, soft drinks, and homemade refreshments in the Alliance's Hospitality Center located in meeting room B.

The MSMA Alliance will hold a silent auction during the Membership Party on Saturday evening, May 14.



**APRIL 1994** 

#### MSMA 126th Annual Session and Scientific Assembly May 11-15, 1994 Ramada Plaza • Jackson, MS

#### PROGRAM OVERVIEW

Wednesda	* - · · · ·		ay 13 - continued
11:30 am	Golf Tournament - Anandale Country		MS Society of Oncology
	Club - MACM	12:30 pm	MS Neurosurgical Society
1:00 pm	MSMA Registration opens		MSMA Alliance Luncheon - Jackson
3:00	Alliance Hospitality/Auction items display		Country Club
		2:30	MSMA Alliance Postconvention Board
<u>Thursday,</u>		4.00	Meeting - Jackson Country Club
8:00 am	Exhibits Open - Continental Breakfast	4:00	MPIC - Annual Stockholders Meeting
	MSMA Registration	5:00	MS State University Medical
	MSMA Reference Committee Breakfast	5.20	Alumni Reception
9:00	MSMA House of Delegates	5:30 6:00	MACM Hospitality
	Alliance Hospitality Center	0.00	Tulane University Medical Alumni Association
11:00	MSMA Alliance Preconvention Board		7130001441011
	Meeting/Luncheon		UMC Alumni Business Meeting and Dinner - Riverhills Country Club
11:30	MSMA Member/Exhibitor Lunch in	9:00	President's Dessert Reception
10.00	exhibit hall	9.00	honoring Don Q. Mitchell, MD, hosted by
12:00 noon	Resident Physicians Section		Millsaps College
1.00	Meeting - UMC R-354		winisaps Conege
1:00 pm	MS Foundation for Medical Care	Cotumdon	Mov 14
1:30	Membership Meeting	Saturday,	
1:30	MSMA Reference Committee on Constitution and Bylaws	7:00 am	MS Chapter, ACS, Officers and
2:00	MSMA Reference Committee A	9,00	Board of Governors' Breakfast
2.00	MSMA Reference Committee B	8:00	MSMA Registration
	Alliance Tour - UMC Childrens'	8:30	MSMA Surgery Plenary Session
	llospital	8:30	MSMA Fifty Year Club Breakfast MSMA Alliance Past Presidents' Breakfast
6:30	President's Reception - MS Agricultural	10:00	
0.50	and Forestry Museum	10.00	MS Dermatological Society Alliance - Garden Gala
	and Polestry Museum	12:00 noon	MS Chapter, American College of Surgeons
Friday, Ma	av 12	12.00 HOOH	Luncheon/Scientific Session
		1	MS Dermatological Society Luncheon
7:30 am	MSMA Members and Exhibitors Continental		MS Society of Anesthesiologists
	Breakfast A. C.		MS Radiological Society
0.00	MS EENT - Breakfast/Meeting		MS Psychiatric Association
8:00	MSMA Registration	2:30 pm	MS Nephrological Society
	Alliance Registration MSMA Past Presidents' Breakfast	7:00	MSMA/MSMA Alliance Membership Party
		7.00	Mominion in Amarice Membership Lary
9:00	MSMA Alliance House of Dalaceter	Sunday, M	lav 15
7.00	MSMA Alliance House of Delegates - Jackson Country Club	7:30 am	MPAC Board of Directors Breakfast
	Allrance Hospitality - Ramada	7:30 am	Continental Breakfast
12:00 noon	MSMA Council on Medical Education	8:00	Protestant Services
12 (11) (1()())	Many Council on Medical Education	0.00	Trotestant Services

MS Society of Internal Medicine MS Academy of Family Physicians

MS Society of Addiction Medicine

A ademy of Pediatrics

Catholic Services - St. Richard Catholic

MSMA House of Delegates

Church

12:00 noon Adjournment

9:00

### **Educational Program**

### The Coming Health Care Revolution In Mississippi

#### SESSION - I

FRIDAY, MAY 13 . ROOM C

8:30 AM	The Future Ain't What It Used To Be
	JAMES GRANT THOMPSON MEMORIAL LECTURE
	Howard Lang, MD, Immediate Past Chairman, AMA Hospital Medical Sta
	Section
9:15 AM	Employer's look at Health Care Reform
	Pat Yarbrough Small Employers - representing Metro Jackson
	Chamber of Commerce
	Susan Cane Large Employers - representing Deposit Guaranty Bank
10:15 AM	Break
10:30 AM	Models of Physician Organizations In the Reform Environment
	Edward B. Hirshfeld, JD, AMA, Associate General Counsel Health Law
11:45 AM	Question and Answer session
Noon	Adjourn

#### SESSION - II

SATURDAY, MAY 14 • ROOM C

## 8:00 AM Vascular Insufficiency in the Upper Extremity J. T. Davis Lecture Paul Weeks. MD. Professor and Chairman of Plastic Su

Paul Weeks, MD, Professor and Chairman of Plastic Surgery, Washington School of Medicine, University in St. Louis.

#### THE COMING HEALTH CARE REVOLUTION IN MISSISSIPPI

11115	COMING HEALTH CARE REVOLUTION IN MISSISSIF
9:10 AM	A View From Washington
	John Scott, AMA, Assistant Director of Congressional Affairs
9:40 AM	A View From Mississippi
	W. Briggs Hopson, MD, Chairman, Governor's Health Care Reform
	Commission
10:10 AM	Break
10:20 AM	A View From California
	Michael Zinner, MD, Chief of Surgery, UCLA College of Medicine
11:00 AM	Is Quality an Issue?
	Robert S. Rhodes, Professor and Chairman of Surgery, UMC
11:20 AM	Panel Discussion
	Mr. John Scott, Dr. Hopson, Dr. Zinner and Dr. Rhodes
Noon	Adjourns

## MSMA MSMA Alliance Membership Party

Honoring Dr. & Mrs. Norman C. Nelson

Saturday, May 14, 1994 Grandball Room • 7:00 - 9:00 pm Ramada Plaza Hotel

MSMA Alliance Silent Auction Benefiting AMA-ERF

Music by the Gators
Fine Food and Spirits

## TECHNICAL EXHIBIT

MSMA 126th Annual Session

Ramada Plaza

Exhibitor	Booth
Abbey Home Healthcare	11
Abbott Laboratories	
Amgen	
Automated Health Systems, Inc.	
Bedsole Medical Companies, Inc.	
Bristol Myers Squibb	
Buckner Prosthetics & Orthotic Laboratories, Inc.	40
Charter Hospital - Jackson	
Charter Lakeside Hospital - Memphis	
DP Associates, Inc.	
IC Systems, Inc.	
Independent Computer Service, Inc	
Key Pharmaceuticals	
Lanier Worldwide	
Medical Assurance Company of Mississip	
Medical Pathology Laboratory, Inc	
Medical Underwriters of Mississippi	4
Memorial Hospital at Gulfport	
Merck Human Health Division	
Miles Pharmaceuticals	
Millcreek Rehabilitation Center, Inc	34
Mississippi Home Therapeutics, Inc	
MS Foundation for Medical Care	
MS Methodist Rehabilitation Center	17
MS State Department of Health	30
MSMA Benefit Plan & Trust	15
National Medical Care (NMC)	21
Pine Grove Recovery Center	3
Puckett Laboratory	28
River Bay Corporation	32
Sims Prosthetics and Orthopedic	
Appliances, Inc.	13
Sta-Home Health Agency	
Syntex Laboratories, Inc.	
The Doctors' Company	
The PIE Mutural Insurance Company	
Travelers Medicare	12
US Air Force Health Professions	
Recruiting	
US Air Force Recruting	
US Army Medical Department	8



#### Mississippi State Medical Association Alliance

71th Annual Session May 11-15, 1994 Ramada Plaza Hotel Jackson, MS

Wednesday, May 11

3:00 PM - 5:00 PM Registration - Meeting Room B

Thursday, May 12

9:00 AM - 4:00 pm Registration - Meeting Room B

Hospitality - AMA-ERF Auction Item Display

11:00 AM Pre-convention Board Meeting/Luncheon -

Cabana II - \$10.00

2:00 PM Tour UMC Children's Hospital -

Reception by UMC Medical Student Spouses

6:30 PM MSMA President's Reception - MS Agricultural

and Forestry Museum - 1150 Lakeland Drive,

Jackson

Friday, May 13

8:00 AM - Noon Registration - Meeting Room B

Hospitality Center - AMA-ERF Auction Item Display

9:00 AM House of Delegates - Country Club of Jackson

12:30 PM Luncheon - \$18.00 - Country Club

2:30 PM Post-convention Board Meeting - Country Club

5:00 PM Alumni Receptions

Saturday, May 14

8:30 AM MSMAA Past Presidents' Breakfast - Magnolia II

10:00 AM Garden Gala - Home of Dr. & Mrs. H. C. Ethridge

7:00 PM MSMA/MSMAA Membership Party/Silent Auction -

Honoring Dr. and Mrs. Norman C. Nelson

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The President's Page DON Q. MITCHELL, MD

#### The Fork In The Road

I 've gone around the state in the past 12 months speaking to the component societies about health care reform and how we have reached a fork in the road. I've reiterated Yogi Berra's response to "What do you do when you come to a fork in the road?" ....... "Take It".

But I also remind you of what Alice said in "Alice's Adventures In Wonderland". When reaching a fork in the road she asked the Cheshire Cat, "Which fork do I take?" The Cheshire Cat responded, "Where do you want to go"? Alice said, "I don't know", and the old Cheshire said, "Well, what difference does it make"?

My point in all of this is that we need to first chart our course, then travel the road together, wherever that may lead. At this time of debate, more than ever before, physicians need to stick together and speak with one voice. However, on both the national and state level, it seems more and more that physicians are their own worst enemy. Take for example the comment made by the Chairman of the Board of Regents of the American College of Surgeons. After presenting his written testimony before the House Committee on Education and Labor, he reportedly said, "the Regents' support the concept of a single-payer system". This was his opinion — not that of the ACS membership. The media headlines, however, stated "Surgeons Back Single-Payer Health Reform". Articles carried leads such as "The ACS stunned the medical and health-policy world by endorsing a national 'single-payer' health system for the U. S."

This incident, like many others I could name, just further divides us. More importantly attention is diverted from the key issue of health system reform which is what is

(Continued on page 110)

#### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 4 APRIL 1994

## Thou Shalt Not Bear False Witness Against the Government

The President's health plan drifts like the Hindenburg, slowly, monstrously, over the trees. All eyes are on it as it casts it huge shadow on the earth. And then comes the spark, the burst of flame, spreading to engulf the structure as it crashes to the earth, the handlers scattering in every direction.

Even the White House now admits that the health plan faces radical surgery. Some observers wonder whether Congress will pass anything substantive. Is this good? Perhaps, and perhaps not. Reform proceeds all around us, every day, "health plan" or no. I've joined two or three PPOs, and have a small stack of other proposals I keep shoving to the side of my desk. And that's nothing compared to what doctors in cities larger than Natchez have faced.

It was inevitable that big corporations would try to wedge their way into the large cash flows of the medical care system. Allowed to have their unfettered way, they would have all of us locked into their health plans, obsequiously calling in to request permission to give an enema. Nothing is more ruthless than a corporation threatened with a drop in profits and thus, the loss of their Texas Stadium skybox. CEOs are tossed out on the spot. What hope would a poor doctor have whose patients had lengths of stay two hours over the "norm"?

The greatest fault of the Clinton plan is that it turns the doctors and patients over to the barons, the financiers who will contract with the purchasing collectives. But there are other plans proposed that keep a fairer role for the government. Even the Clinton plan would not look too bad without the premium caps and if provider contracts with the purchasing collectives were limited to groups of doctors operating in a nonprofit manner. Perhaps we should not utter the word "government" with the cynical derisory laugh we often add to it. The government, after all, enforces a near monopoly for us. And the alternative to some government role is wide open free enterprise in which doctors and patients can be very small potatoes. The MSMA and AMA have appealed to the government before, and with reasonable success. We know just who to call and what highway to take to see them in person. Now the market. Well, the market. Yes, the market. Hmm, the market. Well where is it? Who is it? You can open your window and scream into the night, but you'll never find it.

An element of good can come from a government role in medicine. Too much of a role would certainly spoil the pot. But too little? Too little and we will be getting more mail and notices from the barons, and the stack of PPO proposals on our desks will grow higher. In that case, we had better be organized. If you haven't already, go through the stack on your desk and pull out the one from MSMA's Mississippi Physician's Care Network. Give it careful consideration. If the government sells us out to the barons, it's the only foxhole in sight.

Leslie E. England, MD Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

APRIL 1994 109

#### President's Page

(Continued from page 108)

best for our patients. I hear from some of you, that "the AMA does not represent our views", but I would think that most doctors agree with the AMA's basic components of what we desire for our patients:

- 1. Provide universal access and coverage to health care services.
- 2. Establish a standard package of health benefits for every American citizen and legal resident of the United States.
- Guarantee that the quality of care under reform remains at least as high as today.
- 4. To keep decisions about patient care in the hands of doctors and their patients.
- To cut the high cost of professional liability and decrease the cost of medical care by enacting meaningful liability reform
- 6. To preserve the patient's freedom to choose their own doctors, no matter what health plan in which they are enrolled.

There will no doubt be differences in opinions and perspectives about reform elements between generalists and specialists, between state associations and specialty societies, between the AMA and specialty societies as well as within each of these individual organizations. This generally involves such things as increased emphasis on primary care, so-called gate keepers, and shifts in reimbursement emphasis. Most of these differences deal with economic concerns not patient care.

As physicians, when we look at Yogi Berra's question, "What do you do when you come to a fork in the road"? the next question should be like the Cheshire Cat asked Alice, "Where do you want to go"? The answer makes a big difference for it determines our future.

My hope is that we will be able to forge a consensus and "sing from the same page in the hymn book", then our patients, the profession and our country will benefit. I encourage each of you to attend the MSMA 126th Annual Session May 11-15 and express your opinions and concerns on these and other issues.

Your colleague.

#### **LETTERS**

#### Editor, Journal of the Mississippi State Medical Association

I represented the Mississippi State Medical Association on the Governor's Health Care Commission and also strongly supported the final recommendations of the Commission.

Although all of the Governor's plan did not survive the legislative process, I want to thank the Mississippi State Medical Association's Council on Legislation for their courage and unswerving support for the Governor's bill.

Many that were involved in the Governor's Commission had definite reservations concerning the complexity and the potential dangers involved with future government controls and with the structure of the financing authority in the Governor's plan. However, because of the tort reform for our members, and the mandated comprehensive school health education for Mississippi's children, the plan's advantages far outweighed the possible disadvantages.

The Council on Legislation's forward thinking and futuristic vision, particularly concerning means of addressing social-decay issues that have been responsible for a large portion of the health care cost escalation, is much appreciated by me as a practicing doctor interested in social reform.

Even though many times the Council's actions are not well understood by many grass-root members and they are often maligned and criticized for their decisions, I believe they have always considered what was in the best interest of the majority of our members and our patients.

Thank you for you unselfish sacrifice to the citizens and doctors of the State of Mississippi.

Sincerely,
J. Edward Hill, MD
Past President,
Mississippi State Medical Association
Member,
Governor's Health Care Commission

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### WHATEVER HAPPENED TO PRIMUM NON NOCERE?

There is probably not one single member of the Mississippi State Medical Association who is unaware that our state legislature is currently in session considering bills of interest to all of us in the MSMA. However, there may be quite a few of you who do not know of an event which took place on Friday, February 4, 1994. First, you need a little background information. In the 17 years I've been in practice, every year there has been introduced into the legislature a bill which would allow non-medical personnel (optometrists) to treat eye diseases. Each year the ophthalmologists, with the support of the MSMA, have been able to defeat this bill in a committee or subcommittee. A similar bill was introduced again this year and as the "blue letter" stated on Thursday, February 3, 1994, it had once again been defeated in committee. There was a cautionary statement in the "blue letter", however, stating that the fight was not over yet as the optometric bill was likely to be added as an amendment to another bill which would require a vote by the entire Senate— this bill was the Governor's health plan bill which the MSMA had rightfully been supporting. The membership of the MSMA was assured of the Association's continued opposition to the optometric bill in the aforementioned "blue letter". Then came a dramatic turn of events. On the very next day, Friday, February 4, 1994, the Council on Legislation of the MSMA (which consists of 8 physicians, one from each of the 8 districts in the state) had their usual Friday telephone conference call to discuss MSMA's position on various bills before the legislature. Now, admittedly, none of the members of the Council necessarily had any personal knowledge of patients having suffered from being seen and treated by optometrists, but they and the leadership of MSMA have certainly been made

aware of such cases. Many members of the state EENT Association have invested hours (years, really) telling anyone who would listen of the dangers of allowing non-medical personnel to treat our patients. Regardless, the Council voted 8 to 0 to support the above mentioned bill—this bill specifically allows optometrists to "use topical pharmaceuticals", i.e, to treat glaucoma, iritis, hyphoma, infections, etc. Subsequently, there was passed by the Senate a bill which allows optometrists to do any surgery done under topical anesthesia!

One of the most basic tenets of the Hippocratic Oath is "first, do no harm". I firmly believe that Hippocrates had in mind the patient first when he included this in his oath which we all swore to upon receiving the MD degree. It might be that now we must swear allegiance to the "Hypocrite Oath" which says, "me first, the patient can look out for himself"! It would certainly be interesting to know the reasoning of the Council on this issue (their names are listed on page 9 of the 1993 MSMA Membership Directory). I would urge each of the members of the MSMA to look into this matter with their district's representative on this Council. Who's next? Chiropractors, audiologists, etc.?

As of the writing of this letter, the bill allowing optometrists to essentially become physicians by legislation is being debated in the House of Representatives. Regardless of the outcome, we cannot hold the legislature responsible for the welfare of our patients since elected officials haven't taken the oath of "first, do no harm". The real culprit in this disaster is "our" own MSMA! Whatever happened to <u>PRIMUM NON NOCERE?</u>

William C. Mayfield, Jr., MD

Jackson

# AN OPEN LETTER FROM THE COUNCIL ON LEGISLATION TO THE MSMA MEMBERSHIP:

As members of the MSMA Council on Legislation, we want to clarify the circumstances surrounding optometry scope-of-practice legislation and our actions in regard to this issue throughout the 1994 Legislative Session.

At the Council's initial meeting on January 14, we asked the Executive Committee of the MSMA Board of Trustees, MSMA officers and the President of the Mississippi EENT Association to meet with us to discuss various bills that had been introduced to expand the scope of practice of optometry. At that time we were advised by the MSMA lobbyist that, although we had been successful in defeating this legislation for several years, the prospects for doing so in 1994 were extremely remote for a number of reasons, not the least of which was a strong desire by the legislature to dispose of this issue before the 1995 election year.

Given the fact that some form of legislation expanding the scope of practice of optometry was likely to pass in 1994, coupled with MSMA's desire to concentrate its primary lobbying efforts on the passage of tort reform legislation, the Council discussed the advisability of seeking some sort of compromise in order to limit the scope of any law ultimately enacted. In that regard, we reviewed what had occurred in states such as North Carolina, where optometrists were authorized to do surgery and Louisiana, where the medical society maintained that compromising on the issue would have avoided the adoption of more liberal scope-of-practice language. The President of the Mississippi EENT Association, however, made it clear that the majority of his members were unalterably opposed to compromising with optometry on the scope-of-practice issue and that they did not want to do so even at the risk of seeing more onerous language enacted.

Even though it was the consensus of the Council that it would be best in the long run to pursue a compromise with optometry in order to limit any scope-of-practice expansion, it was decided that MSMA would

continue to support the EENT Association in opposing any such legislation. However, the Council also decided that it would not oppose legislation limiting optometrists to the use of topical drugs if doing so was necessary to prevent the passage of more onerous language such as the use of oral therapeutics and surgery, or if it was necessary to avoid jeopardizing the enactment of medical liability reform.

On February 2, the legislative deadline for general bills to be reported out of committees, all optometry legislation that had been introduced for the 1994 session died in committee. In its weekly conference call on February 4, the Council was informed of this and was also told that the optometrists were going to attach a scope-of-practice amendment to the bill (SB 2624) containing the recommendations of Governor Fordice's Health Care Commission. Included in these recommendations were the tort reform proposals that the Council considered to be its highest legislative priority. The Council was further advised that Sen. John White, the optometrist from Baldwyn, had prepared an amendment to SB 2624 that would allow optometrists to do anything they were "taught" in optometry school, including surgery, and medicine did not have the votes in the Senate to defeat the amendment.

In view of the fact that SB 2624 was going to be amended to include a very liberal optometry scope-of-practice expansion, we were faced with the prospect of ultimately trying to defeat the tort reform legislation. Given that fact, the Council voted unanimously to continue to support SB 2624 if the optometrists would agree to limit their efforts to expand their scope of practice to the use of topical drugs AND as long as the tort reform remained in SB 2624.

Immediately after the February 4 conference call, the President of the Mississippi EENT Association was advised of the Council's decision to pursue a compromise on the optometry issue.

Over the course of the next three days, MSMA's

lobbyist persuaded the optometrists to confine their scope-of-practice amendment only to the use of topical and over-the-counter drugs and to agree that they would make no effort to further expand their scope of practice for the remainder of the 1992-95 legislative term. The compromise optometry amendment was passed overwhelmingly by the Senate on February 8, although SB 2624 was narrowly adopted on final passage due to opposition of the trial lawyers and others to the tort reform provisions in the bill. The Senate also adopted an additional amendment that strengthened the 1920 statutory prohibition on the practice of surgery by optometrists.

Once SB 2624 passed the Senate the Council was aware that survival of the tort reform in the House was dependent upon the bill not being referred to the Judiciary Committee. The Council believed, however, that the tort reform had to pass the Senate before we ever had a chance to attempt to persuade the Speaker to refer the bill solely to the House Public Health Committee. After SB 2624 passed the Senate with the optometry language, however, Speaker Tim Ford received a large number of calls from physicians asking him to refer the bill to the Judiciary Committee even though we had urged through the "Blue Sheet" that physicians urge him not to do so.

In the end, SB 2624 was doubly referred to both the Public Health and Judiciary A Committees. Referral to the Judiciary A Committee meant that the tort reform in SB 2624 had no further chance of passage; therefore, in its February 17 conference call, the Council agreed that the bill should be opposed. In deciding to oppose SB 2624 we were aware that the optometrists were no longer bound to their agreement not to pursue any scope-of-practice changes beyond those previously agreed upon in formulating the compromise and that they would probably seek a more liberal practice expansion.

On February 23, SB 2624 was killed in a subcommittee of the House Public Health Committee. That same day, Senator John White introduced a bill to impose a \$25 privilege tax on optometrists. As a "revenue" measure, this bill (SB 3321) could be introduced after the deadline for introducing "general" bills and its passage required a three-fifths, rather than majority, vote.

On February 24, when SB 3321 came before the full Senate, Senator White offered an amendment to allow optometrists to use therapeutic drugs and perform surgery involving topical anesthetics. The amendment was adopted and SB 3321 then passed the Senate with the necessary three-fifths vote, even though it was strongly opposed by MSMA and the Mississippi FENT Association.

In the House of Representatives, SB 3321 was referred to both the Public Health and Ways and Means Committees. On March 3 both committees voted to report the bill to the full House after removing the language permitting optometrists to do surgery.

On March 10, when the House took up SB 3321 it was ruled to be improper as a result of several procedural "points of order" made by friendly House members. SB 3321 was dead.

On March 16, a House Concurrent Resolution was introduced to allow introduction and consideration of a new optometry bill, again after the legislative deadline for acting on such matters. Despite the opposition of MSMA and the EENT Association, this resolution passed both houses by March 22.

On March 26 and 28 respectively, the Senate and House passed legislation authorizing optometrists to use and prescribe therapeutic <u>topical</u> drugs. Additionally, the bill allows optometrists to:

- 1. "diagnose, manage and treat" diseases and conditions of the eye;
- 2. remove foreign bodies and perform other "noninvasive" procedures, while prohibiting any kind of invasive surgery; and
- 3. provide postsurgical care and management with the advise and consultation of the operating surgeon.

The Council notes that many ophthalmologists prefer the scope-of-practice language that was ultimately adopted by both houses of the legislature to the Council's compromise because of the strenthened prohibition against invasive surgery.

We hope that this information clarifies the events surrounding consideration of optometry legislation this year and our actions in this regard.

### Sincerely, THE COUNCIL ON LEGISLATION

John F. Lucas, III, M.D., Greenwood, Chairman William A. Middleton, M.D., Winona R. Ray Lyle, M.D., Starkville John J. Cook, M.D., Jackson John C. Clay, M.D., Meridian H. Allen Gersh, M.D., Hattiesburg David G. Hall, M.D., Natchez Steven Demetropoulos, M.D., Pascagoula Mrs. Eric (Nancy) Lindstrom, Laurel, MSMA Alliance Don Q. Mitchell, M.D., MSMA President, Ex-officio member Mal G. Morgan, M.D.,

## **Medical Organization**



Frank J. Morgan, Jr., MD, left, and Julian C. Henderson, MD, right.

#### Clare Hester Joins Pfizer Pharmaceuticals Group

Clare L. Hester, MSMA Director of Legislative Activities and staff member since January of 1987 resigned in February to accept a position with Pfizer Pharmaceuticals, Inc. in Boston, Massachusetts.

Ms. Hester will be the regional public affairs representative for Pfizer working in Massachusetts and surrounding states.

# **Dr. Morgan Receives Recognition From Central Medical Society**

Frank J. Morgan, Jr., MD was recognized by Central Medical Society for his years of service as executive officer of the Mississippi State Board of Medical Licensure. Julian C. Henderson, MD, a member of the Central Medical Society executive committee and MSMA Board of Trustees presented Dr. Morgan with a resolution at a recent society meeting.

The resolution stated that Dr. Morgan has served with distinction in the capacity of executive officer since 1980. Dur-

ing this time Dr. Morgan received many honors and national recognition of outstanding service by the Board, and individual recognition as the 1993 recipient of the Federation of State Medical Licensing Board's Dr. John H. Clark, Leadership Award. The resolution further stated that the society commended Dr. Morgan for his outstanding service on behalf of the public and the profession.

Dr. Morgan retired as executive officer of the board on December 31, 1993. □

COMMENTS or QUERIES....

The Editors of *Journal MSMA* invite you to comment on any material that appears in or is absent from the publication.

If you have a query or comment, please send it to:

The Editor, Journal
MSMA,
PO Box 5229, Jackson,
MS 39296-5229

## The University of Mississippi Medical Center

# Family Practice Residency Program To Be Established

North Mississippi Health Services (NMHS) in Tupelo and UMC announced the establishment of a family residency program in Tupelo.

"The affiliation between NMHS and UMC will result in the first free standing residency program outside of Jackson," George Hand, NMHS administrator, said.

"Mississippi is one of two of the most medically underserved states in the U.S. We are working diligently to improve access to health care in our region. This affiliation between NMHS and UMC will enable us to provide much needed primary care. Many communities in this region either lack physicians or have doctors who are nearing retirement age," John D. Hicks, NMHS president said.

Dr. Lessa Phillips, professor and chairman of the Department of

Family Medicine, said family practice residents will also benefit.

"The Medical Center has experience in the academic world, and NMHS has experience in the community. This combination of our strengths will give family practice residents a wonderful opportunity to learn," Dr. Phillips said. "Students will be able to choose to continue their residencies in either a university or a community setting. In the past, students trained in communities on a short-term basis. With a freestanding program in Tupelo, students will be able to spend 24 months in a community."

NMHS will file for accrediation from the Accreditation Council for Graduate Medical Education (ACGME), which will review NMHS's application and conduct a site visit of North Mississippi Medical Center's campus. Accreditation could be received as early as July 1994. UMC's family practice residency program received its ACGME accreditation in 1973.

The Tupelo-based program will initially accommodate four to six family practice residents. Residents will complete the first year of their three year residency at UMC, and the remaining two years will be served in Tupelo. First participants in the program would begin studies in Tupelo in July 1995, according to Hand.

In addition to treating patients, residents will do rotations in surgery, ob-gyn, pediatrics, internal medicine and other subspecialties. Also, residents will receive training through NMHS's extensive network of family practice clinics in 17 communities and community hospitals in Eupora, Iuka, Pontotoc and West Point.

Salaries for residents, faculty members and other physicians who participate will be provided by HMHS. All physicians who supervise the resident's training will be members of the UMC family medicine department faculty.

# Dr. Martin Elected To SPO Board

Dr. James N. Martin, professor of ob-gyn, was elected to the board of directors of the Society of Perinatal Obstetricians (SOP) the primary scientific body of maternal-fetal medicine (MFM) special-

ists in the United States.

In addition, Dr. Martin serves on the American College of Obstetricians and Gynecologists Committee on Obstetrics — Maternal-Fetal Medicine, which oversees and evaluates obstetric practice in this country. Dr. Martin was also elected president-elect of the Society of the Study of Hpertension

in Pregnancy for a three-year term. At the end of his current term, he will serve a three year term as president of the organization which is the North American arm of the international Society for the Study of Hypertension in Pregnancy which includes the United States, Mexico and Canada.

# Dr. Scott-Conner SAGES Presenter

Dr. Carol Scott-Conner, professor of surgery, has been invited to serve as a faculty member at the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) 1994 Scientific Session and Postgraduate Course.

She will present a lecture entitled "Conscious Sedation and its Problems" at the SAGES annual conference in April. 

□

# Dr. Vance Appointed To Cancer Society Executive Committee

Ralph Vance, MD, professor of medicine, has been appointed to the executive committee of the national American Cancer Society (ACS). Dr. Vance has been a volunteer for the Mississippi Divison of ACS for the past 16 years. He has been chairman of the professional education committee, president of the board of directors and

chairman of the executive committee. Since 1984, he has chaired the division's Camp Rainbow, a camp for childern with cancer in Mississippi.

At the national level, Dr. Vance has served on many committees including Questionable Methods of Cancer Management and Pain Relief and currently chairs the national special events committee.

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### **New Members**

Barnett, David E., Jackson. Born Nashville, TN, August 17, 1956; MD, University of Tennessee College of Medicine, Nashville, TN, 1988; anesthesiology residency, Same, 1989-92; elected by Central Medical Society.

Bell, William Scott, Southaven. Born Memphis, TN, February 26, 1964; MD, Louisiana State University School of Medicine, Shreveport, LA, 1989; internal medicine residency, Baptist Memorial Hospital, Memphis, TN, 1989-92; elected by Desoto County Medical Society.

Bradford, Nathan F., Greenville. Born Memphis, TN, July 5, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; medicine & pediatric residency, Vanderbilt University, Nashville, TN, 1989-93; elected by Delta Medical Society.

Drake, Lee B., Amory. Born Batesville, MS, September 10, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; ob-gyn residency, Emory University, Atlanta, GA, 1989-93; elected by Delta Medical Society.

Gary, John David., Ocean Springs. Born Greenville, MS, January 5, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1984; interned, inedicine residency and pulmonary fellowship, University Medical Center, Jackson, MS, 1984-80; elected by Singing River Medical Society.

Halaris, Angelos E., Jackson. Born Greece, November 30, 1942; MD, University of Munich Medical School, Munich, Germany, 1967; rotating internship in surgery, obgyn, 1968-70; psychiatry residency, University of Chicago, Chicago, IL, 1971-74; elected by Central Medical Society.

Lemos, Luciano B., Jackson. Born Sao Paulo, Brazil, September 22, 1948; MD, Escola Pauusta Medicina, Sao Paulo, Brazil, 1972; interned one year, same; pathology residency, Ohio State University School of Medicine, Columbus, OH, 1974-76; pathology residency, Memorial Sloan-Kettering, New York, NY, 1976-78; elected by Central Medical Society.

Montalvo, Ray A., Jr., Brookhaven. Born New Orleans, LA, December 5, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; internal medicine residency, University of California at Davis, Sacramento, CA, 1986-89; elected by South Central Medical Society.

Morrissette, Charles T., Hattiesburg. Born Memphis, TN, June 27, 1961; MD, University of Tennessee College of Medicine, Memphis, TN, 1987; internal medicine residency, Same, 1987-90; gastroenterology residency, same, 1990-92; elected by South Mississippi Medical Society.

Murphey, Steven M., Hattiesburg. Born Tupelo, MS, January 24,

1954; MD, University of Mississippi School of Medicine, Jackson, MS, 1984; radiology residency, Ochsner Clinic, New Orleans, LA, 1984-89; elected by South Mississippi Medical Society.

Norsworthy, T. Philip, Indianola. Born Laurel, MS, November 11, 1956; MD, University of Mississippi School of Medicine, Jackson, MS, 1982; family medicine residency, University Medical Center, Jackson, MS, 1982-85; elected by Delta Medical Society.

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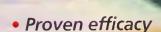
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Cartinogenesis, Mulagenesis, and Impairment of Fertility: In an 18-month processing the titude in more and a Claritic description.

pared to placebo

Cartinogenesis, Mulagenesis, and Impairment of Fartility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loraladine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. ALIC data demonstrated that the exposure of mice, given 40 mg/kg of loratadine was 26 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/dgy. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/dgy. The discussion of the description o

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REPORTED A OVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACE80-CONTROLLEO ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg 00 n = 1926	<b>PLACEBO</b> n = 2545	1 mg 810 n = 536	TERFENADINE 60 mg 810 n = 684
Headache Somnolence	12	11	8 22	8 9
Fatigue Ory Mouth	4 3	3 2	10 4	2 3

Adverse event rates did not appear to differ significantly based on age sex or race although the number of non-white sub-jects was realively small in addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients

In addition for those adverse events reported above, the following adverse events have been reported in 2% or fewer patients, advinorince Memorius System. Aftered salvation in increased sweating aftered activation hypoestress are impotence, thirst flushing Body As A Whole. Conjunctivitis, blurred vision, earache eye pain, innitius, astheria weight gain back pain leg cramps, malaise, chest pain, rigors fever, aggravated allergy, upper respiratory infection anjoneurotic dedma. Cardiovascular System. Hypotension, hypotension papirations syncope, tachycardia. Central ano Peripheral Nervous System. Hypotension hippertension papirations syncope tachycardia. Central ano Peripheral Nervous System. Hyperkinesia blepharospasm paresthesia dizziness migraine fremor, vertigo, dysphona. Gastrointestinal System. Activational distress nausea, vomiting flatulence gastritis, constipation, diarrhea altered taste increased appetite, anorexa, dyspepsia, stomatris, toothache. Musculoskeelar System. Arthrigg, myalga. Psychatric. Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido. netrousness.

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Reproductive System—Brast pain menorthaga, dysmenorthea vaguntis
Reproductive System—System Nesal dyness, epistais, pharyngitis, dyspinea nasal congestion, coughing, thinitis, hemophysis, sinusitis sixening, forenchospasm, bronchist, laryngitis.
Sixii and Appendages—Dermatitis, dyn hair dry skin, urticare rash prurfus, photosensitivity reaction, purpura Unrany System—Unrany disciplination, affected microtron—In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratatine peripheral edema abnormal hepatic function.

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1. Bédard P-M, Del Carpio J, Drouin MA, et al. Diset of action of loratadine and placebo and other efficacy variables in patients with seasonal allergic rhinitis.

Clin Ther. 1992:14:268-275.

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#### New Members /continued

Russell, Donald B., West Point. Born Mississippi, April 27, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; radiology residency, Medical College of Virginia, Richmond, VA, 1987-91; fellowship, trauma & interventional radiology, University of Maryland, Shock-Trauma Center, Baltimore, MD, 7/91-12/91; elected by Prairie Medical Society.

Simpson, Don E., Corinth. Born Monroe, LA, February 18, 1951; MD, The University of Texas Medical Branch, Galveston, TX, 1989; ob-gyn residency, Same, 1989-93; elected by Northeast Medical Society.

Spraybery, A. Trev, Southaven. Born Tupelo, MS, August 17, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; interned one year, Methodist Hospital, Memphis, TN; internal medicine residency, Baptist Memorial Hospital, Memphis, TN, 1988-90; rheumatology fellowship, same, 1991-93; elected by Desoto County Medical Society.

Stone, Van D., III, Tupelo. Born Marks, MS, August 20, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1983; pediatric internship & residency, Arkansas Children's Hospital, Little Rock, AR, 1983-86; elected by Northeast Mississippi Medical Society.

Ward, Emily Wofford, Jackson. Born Memphis, TN, June 12, 1956; MD, Jefferson Medical College, Philadelphia, PA, 1981; pathology residency, University Medical Center, Jackson, MS, 6/82 - 6/84 & 7/85-3/87; forensic pathology fellowship, University of Alabama at Birmingham, AL, 1987-88; elected by Central Medical Society.

Washburn, Lisa K., Jackson. Born Shelby, NC, December 19, 1960; MD, Bowman Gray School of Medicine, Winston-Salem, NC, 1987; pediatric residency, same, 1987-90; neonatal-perinatal medicine fellowship, same, 1990-93; elected by Central Medical Society.

REINSTATED

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon\* is indicated as a sympathicolytic and mydriatric. It may have activity as an approdisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.  $^{1,3,4}$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $\frac{1}{2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks,  $^3$ 

How Supplied: Oral tablets of Yocon\* 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
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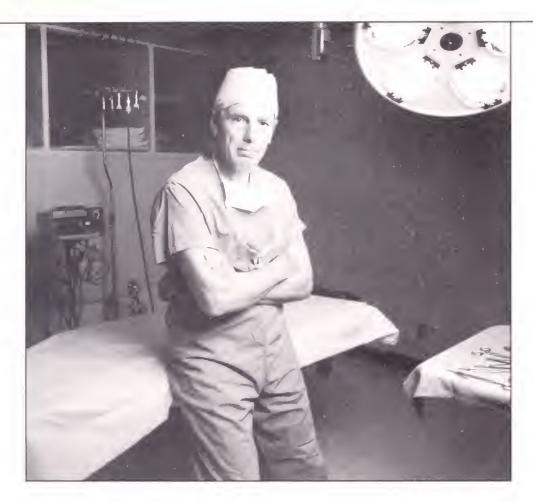
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#### **Personals**

Thomas F. Adams an internist in Columbus has been elected to the advisory board of Deposit Guaranty National Bank in Columbus.

Julius Bosco, Jr., of Pascagoula has been board certified in Obstetrics and Gynecology after passing the final board examination in Chicago and is now a diplomate of the American College of Obstetrics and Gynecology. While completing his residency in OB/GYN at Tulane Medical Center, he was named Chief Resident and received the Hiram WK Baston, MD, award for outstanding resident, and the Isadore Dyer, MD, award for teaching excellence.

Charlton H. Barnes has associated with Chris E. Wiggins and John W. Cope for the practice of orthopedic surgery, Mississippi Coast Orthopedic Group, PA, 3615 Hospital Road, Pascagoula.

C. Ron Cannon of Jackson served as test item writer for the American Board of Facial and Plastic Surgery for their certifying exams. He has been appointed to the executive committee of the Florida Governors for the American Academy of Otolaryngology Head & Neck Surgery. In January he presented a paper at the Surgery Section Triology Society meeting at Marco Island, FL.

Milton D. Concannon, a cardiologist, has associated with Internal Medicine Clinic, 1504 20th Avenue, Meridian.

Roy Duncan of Pascagoula has recently been appointed an Associate Councilor by the Southern Medical Association for the State of Mississippi.

Benton M. Hilbun of Tupelo presented a paper to "SWOG" Summer/Winter OB-GYN Association in

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#### Personals/continued

January in Snowmass, Colorado at the *Update Breast Cancer*.

**Sherry Martin** of Tupelo received ABIM Board Certification in Diabetes, Endocrinology and Metabolism.

**John J. McGraw** of Laurel has recently been appointed an Associate Councilor by the Southern Medical Association for the State of Mississippi.

Clyde Ray McLaurin of Jackson has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians (AAFP).

**Hughes Milam** of Tupelo has been recertified by the Board of Urology.

Henry P. Mills has associated with Curtis Whittington, Jr., W. Granville Tabb, Jr. and Toni J. Bertolet at Mississippi Eye Care Associates, in Jackson for the practice of ophthalmology.

Clyde Sheehan of Tupelo received his board certification in psychiatry, January 10. 1994.

Harold Davis Simmons of Grenada has been elected to fellowship in the American Academy of Pediatrics.

G. S. Stewart, Jr., has associated with the Family Health Clinic of New Hope, 2110 Lake Lowndes Road, Columbus.

Antonne Tannehill of Tupelo was named 1994 "Tupelo Outstanding Citizen" selected by the Junior Auxiliary of Tupelo.

J. Edward Ulmer has associated with Edward L. Carruth and John E. Mann at the Immediate Care Clinic, 1710 14th Street, Meridian.

Kary Whitehead of Meridian has been certified as a Diplomate in Critical Care Medicine by the American Board of Internal Medicine.

Tom Wooldridge of Tupelo was elected president of the Mississippi Nephrologic Society for 1994-95.



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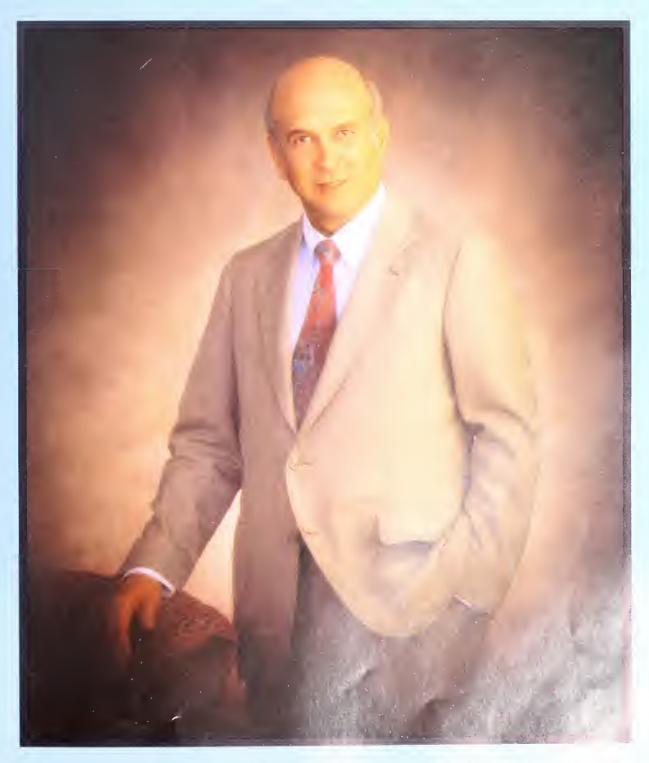
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### **Dateline**

# Journal of the Mississippi State Medical Association Volume XXXV, Number 5

#### **Young Smokers**

Jackson, MS — Thousands of Mississippi's teenagers will become addicted to cigarettes this year unless new action is taken to protect their health, according to state health officials.

The Surgeon General's report on tobacco use, found that tobacco is often the first drug used by young people who use alcohol and illegal drugs. Of the 3.1 million current adolescent smokers, most want to quit smoking but are unable because they are addicted to the nicotine, the Surgeons General's report found.

"The question is not, 'How do we get our young people to stop smoking?" said Cheryl Grubbs, tobacco prevention coordinator with the Mississippi State Department of Health, "but instead, 'How do we help our young people no longer want to smoke in the first place?"

"Nicotine is a drug advertised as being normal, and the magic answer for thinness, popularity, and fun" she said. "What these ads don't tell our young smokers is that they will likely be our adult smokers awakened by coughing at five in the morning or unable to climb a flight of stirs without losing breath."

The Surgeon General's new report found virtually no decline in smoking rates among teens during the past ten years. Moreover, a recent study for the National Institute on Drug Abuse reported that youth smoking rates actually increased last year for both boys and girls, particularly among white males.

In 1993, 19 percent of high school seniors reported smoking at least one cigarette each day for the previous 30 days, up from 17 percent in 1992. Nearly 23 percent of white high school seniors reported daily smoking.

In Mississippi, 28 percent of white high school seniors reported smoking at least one cigarette in the past month.

Although the law prohibits selling tobacco products to minors in all states — including Mississippi — the new report found that up to 87 percent of underage youth are able to purchase cigarettes over the counter. Laws restricting youth access to tobacco are rarely enforced, Grubbs said.

Many adults and merchants don't know Mississippi law prohibits selling tobacco products — including snuff — to minors.

The Mississippi State Department of Health last year joined forces with other public and private agencies in a statewide initiative to curb tobacco use among youth. The State Department of Health supports current initiatives to raise awareness about tobacco advertising aimed at youth, educate the very young — even preschoolers — about the dangers

(continued)

of tobacco, promote comprehensive school health programs, and establish the Mississippi Tobacco Free 2000 Coalition.

For more information about any of these activities, readers may contact Cheryl Grubbs at 960-7434.

\* \* \*

# Immunization Initiative

Ninety-eight percent of Mississippi's school-age children carry vaccine protection against childhood diseases, but too many of the most vulnerable — the infants and toddlers — remain unsafe.

All children should complete immunizations before age two.

In Mississippi, parents do a great job of getting children their first few vaccinations at two, four, and six months. But the follow-up immunizations they should get at 12 to 15 months are often postponed or forgotten, said Liane Hostler, director of MSDH's Immunization program.

"Most of Mississippi's unprotected children need just one more immunization visit to guard against 11 potentially life-threatening diseases," Hostler said. "Almost all our younger children would be fully protected if we could just get them in for that final visit."

Often, a combination of vaccines against various diseases can be administered through a single shot. But parents need to take their children for at least four visits to ensure the effectiveness of all vaccinations.

To remind parents about the need to vaccinate on time, some public health districts in Mississippi now review their clinic's immunization records and prompt parents through letters and phone calls.

"Both private and public providers work hard to get our children immunized," Hostler said. "We've found that this extra effort on our part can help so many children. Most parents we call thought their children already had all their immunizations."

National Immunization Week only begins the nation's and Mississippi's efforts to see more fully protect all children. Through the rest of the year, the State Department of Health will continue to work with both private and public partners to reinforce the message that immunizations save lives. Tentative plans include a mobile immunization clinic as well as immunization reminders on grocery bags and fast food restaurant tray liners.

One key partner involves several organizations: The Mississippi Children's Immunization Awareness Project — a collaborative force dedicated to improving the immunization status of all Mississippi children. Sponsoring groups with the Department of Health are the Mississippi Chapter American Academy of Pediatrics and the Mississippi Nurses' Association; Dr. Robert L. Abney, III, directs the Project.

"The point we need to stress is that young children need a series of immunizations," Hostler said. "If a baby gets her first two shots, that's good. But to be fully protected, she needs a few more."

\* \*

## **Original Articles**

## Radiosurgery of the Brain

Robert R. Smith, MD Anupam Routh, MD William Russell, MD Sharon Holman Ali Lavassani Mike Harrison Betty Hall

S tereotaxy was developed for neurosurgical use in 1947 by Spiegal for biopsy of deep lesions and for the ablation of specific targets in the treatment of functional disorders. The system used three dimensional coordinates in order to deliver a probe to a specific target inside the brain. A needle or electrode was commonly used to produce a thermal or chemical lesion in the subcortical structures, preserving the overlying cortex from resection. Leksel, in 1951 coupled ionizing radiation with the method in order to ablate small areas of the brain in the treatment of Parkinson's disease or for pain management. A helmet containing multiple Co<sup>60</sup> sources was used to make the first "Gamma Knife". More recently, using powerful computers, the linear accelerator has been

modified as the lesion source, thus extending the availability of radiosurgery to many patients with intracranial lesions. As availability expanded, so did indications for treatment. It is now known that many lesions that were considered inoperative are curable using radiosur-gery and many more lesions can be controlled with far less morbidity and mortality than that associated with open craniotomy.<sup>15</sup>

Radiosurgery differs from radiotherapy in both technique and principle. The highly focused treatment is delivered in a single fraction. The issue of radiosensitivity is less important because the lesion produced may be due to necrosis or thrombosis and is not dependent on selective vulnerability of certain cells. There is a steep gradient of radiation at the margin of the lesion and adjacent normal brain escapes the effect.<sup>11</sup>

Complications of radiosurgery occur infrequently. Hair loss is normally not a problem but when it occurs, it is temporary. There is no nausea, vomiting, or skin changes due to the treatment. The lesion produced is nearly round but can sometimes be modified slightly using linear accelerator technology. The technique presently calls for rigid fixation of the head for both the imaging of the lesion and its radiosurgical treatment.(FIG 1) This is accomplished by attaching a rigid frame onto the skull with small pins which are screwed into the outer table under local anesthesia. The treatment itself requires only an hour or less and can be made available to the outpatient.6

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Figure 1. The patient with the head fixed in the localizing ring and frame prepared for linac based radiosurgery.



Figure 2. Large pituitary tumor causing headache. The tumor extends out of the sella turcica and compresses the optic chiasm.

#### CASE PRESENTATIONS

A 35 year old female was referred for radiosurgery because of headaches associated with a pituitary tumor. She had declined conventional surgery. The examination disclosed slight obesity but no evidence of endocrinopathy. There

was no visual field defect to confrontation. Preoperative CT scan is shown in Fig 2. The lesion was treated with a 1.25 centimeter collimator delivering 1500 cGy to the isocenter of the tumor using 300 arc degrees and 8 beams. Post treatment, the patient was discharged home the next day, during the 2nd post operative week, she experienced transient visual dimming and was found to have left temporal field deficit. This had improved by the 2nd post treatment examination. The CT scan on the 2nd postoperative month showed a central area of necrosis within the tumor in the area of treatment. Fig

As of June, 1993, the University series consists of 27 patients treated for arteriovenous malformations(9), benign tumors(6), malignant primary tumors(9) and metastatic tumors(3). Postoperative seizures and brain swelling have occurred in one patient each and both responded to medical management. Three patients with malignant brain neoplasms have died secondary to their disease. Postoperative angiography has not been carried out on any patient with arteriovenous malformations and thus the results of treatment are not yet known. Angiography is contraindicated for one year after stereotaxic radiosurgery.

#### DISCUSSION

Since its introduction in Europe, almost 40 years ago, the number and variety of cases treated with radiosurgery has expanded exponentially. With the introduction of over 100 instruments in the US, reports of treatments are appearing regularly in the neurosurgical literature. Initially, radiosurgery was conceived for the management of vascular lesions which were located deep within the brain and



Figure 3. Two months following radiosurgery there is a lucent area within the tumor suggesting necrosis. Later, tumor shrinkage occurred.

#### REPORTED INDICATIONS FOR RADIOSURGERY

Acoustic Neurinoma
Astrocytoma
Arterial Aneurysm
Arteriovenous Malformation
Carotid Cavernous Fistula
Cavernous Angioma
Choroid Plexus Tumor
Ependymoma
Functional Radiosurgery and Pain
Germinoma

Glioblastoma
Glomus Tumor
Hemangioblastoma
Lymphoma
Medulloblastoma
Meningioma
Metastasis
Oligodendroglioma
Pinealoma
Pituitary Tumor

#### TABLE 1

those that were considered refractory to conventional surgical approaches.<sup>3</sup> More recently, the list of indications has expanded.<sup>4</sup> Table 1.

For arteriovenous malforma-

tions, the results have been particularly encouraging. Obliteration of the small lesion can be achieved in 80-90% of cases and reported complications have been minor.<sup>14</sup> In most cases, a latent period prior

to complete angiographic occlusion of the lesion is about 1-2 years. For large lesions, over 3 cm in diameter, the cure rate is less and volume dependent.<sup>5,9,13</sup>

Radiosurgery is particularly well suited for the metastatic lesion. 1,4,10 These are normally round and fit perfectly the lesion produced by the radiosurgical beam. Engenhart et al reported neurological improvement in 81% of cases treated within 3 months. Imaging studies showed complete remission in 20%, partial remission in 35%, stable disease in 40%, and relapse in only 5% of patients. Unfortunately, total survival was short but the morbidity of treatment was not as severe as with craniotomy. Multiple metastases were not excluded.3

Radiosurgery is effective in the treatment of certain benign intracranial tumors that are difficult to reach surgically.10,11 Acoustic tumors respond well with low morbidity and no mortality. The recurrence rate after treatment is about 5%, as low as with open posterior fossa craniotomy and cranial nerve damage is much less. Meningiomas also respond to radiosurgery and long term cures have been achieved without complications. For pituitary tumors, the patient without visual field involvement is a suitable candidate.

Stereotaxic radiosurgery has appeal for the treatment of Parkinson's disease, pain disorders, and psychosurgery where ablative lesions have proven efficacy. Recently, Hakansson and coworkers treated 10 cases of trigeminal neuralgia with radiosurgery, achieving good to excellent pain control in each. Only one patient complained of facial numbness. Trials are ongoing for pallidal lesions to lessen the rigidity of Parkinson's disease. 15

The role of stereotaxic radiosurgery for malignant gliomas is currently being written. The idea of a focal treatment for a diffuse malignancy seems inappropriate at first glance. However, the implantation of radiation seeds into neoplasms to achieve central boost in ionization has shown to enhance tumor free longevity. This effect can be also achieved using radiosurgery in a much less invasive way. In most cases where tumor recurs after conventional treatment, the margin within one centimeter of the primary nodule is the site for this recurrence. After a mean follow up of 19 months of radiosurgery for malignant glioma, Loeffler et al had lost only 24% of their patients. This is substantially better than many surgical series. Radiosurgery may be used as adjunctive therapy for the patient with a malignant glioma. Curran and coworkers added focused beam treatment to the lesion center in a series of patients with glioblastoma multiforme and anaplastic gliomas. This therapy added significantly to the longevity of patients treated.

#### **CONCLUSIONS**

Stereotaxic radiosurgery is a cost effective relatively less invasive method for managing many intracranial problems. Effectiveness has been established for the deep lesion, the arteriovenous malformation, acoustic tumors and certain other benign tumors carrying high conventional mortality and morbidity. Clinical trials are ongoing for the management of the patient with malignant gliomas, epilepsy, Parkinson's disease and many other so called functional disorders responsive to ablative lesions.

> 2500 North State Street Jackson, MS 39216

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FOR THE NASAL AND NON-NASAL SYMPTOMS OF SEASONAL ALLERGIC RHINITIS

# Clear Choice In **Antihistamine** Therapy



Nonsedating\*

The incidence of sedation with CLARITIN Tablets (8%) was similar to that of placebo (6%) at the recommended dose.

Rapid-acting<sup>†</sup>

CLARITIN Tablets started working in some patients in as soon as 30 minutes; 65% of patients experienced relief within 2 hours.'

- Once-a-day dosing
- Low incidence of adverse effects

In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

Over 1 billion patient days of worldwide experience

In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P= 04). At 2 hours, 48% of patients receiving placebo experienced relief.

Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P= 03)

Please see following page for brief summary of Prescribing Information.

Clear Benefits From Start To Finish

Once-a-day



### Long-Acting Antihistamine

DESCRIPTION CLARITIN Tablets contain 10 mg micronized foratadine, an antihistamine, to be administered orally. They also contain the following

Inactive ingredients: corn starch, lactose, and magnesium stearate.

Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 382.89, and empirical formula of C22H23CIN2O2; its chemical name is ethyl 4-(8-chloro-5,6-dihydro-11 H-benzo [5,6] cyclohepta [1,2-b] pyridin-11-ylidene)-1-piperidinecarboxylate and has the following structural formula:

CLINICAL PHARMACOLOGY Loratadine is a long-acting tricyclic antihistamine with selective peripheral histamine H<sub>1</sub>-receptor antagonistic activity

Human histamine skin wheal studies following single and repeated 10 mg oral doses of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with CLARITIN Tablets.

Pharmacokinetic studies following single and multiple oral doses of lo-ratadine in 115 volunteers showed that loratadine is rapidly absorbed and extensively metabolized to an active metabolite (descarboethoxyloratadine) The specific enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found equally distributed between urine and feces in the form of metabolic products after 10 days. The mean elimination half-lives found in studies in normal adult subjects (n = 54) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) to the metabolite is greater than exposure to parent loratadine

In a study involving twelve healthy geriatric subjects (66 to 78 years old). the AUC and peak plasma levels (Cmax) of both loratadine and descarbe-ethoxyloratadine were significantly higher (approximately 50% increased) than in studies of younger subjects. The mean elimination half-lives for the elderly subjects were 18.2 hours (range = 6.7 to 37 hours) for loratadine and

17.5 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth daily dose. The pharmacokinetics of loratadine and descarboethoxyloratadine are dose independent over the dose range of 10 to 40 mg and are not signifi-

cantly altered by the duration of treatment. In the clinical efficacy studies, CLARITIN Tablets were administered be-fore meals. In a single-dose study, food increased the AUC of loratadine by approximately 40% and of descarboethoxyloratadine by approximately 15% The time to peak plasma concentration (Tmax) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences would not be expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In patients with chronic renal impairment (Creatinine Clearance ≤ 30 mL/min) both the AUC and peak plasma levels (Cmax) increased on average by approximately 73% for loratadine, and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from that observed in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In patients with chronic alcoholic liver disease the AUC and peak plasma levels (Cmax) of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly clanged from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours respectively, and increased with increasing severity of liver disease. There was con-detable viriability in the pharmacokinetic data in all stud-

ies of CLARITIN Tablets, probably due to the extensive first-pass metabolism Individual histograms of area under the curve, clearance, and volume of distribution showed a log normal distribution with a 25 fold range in distribution in healthy subjects

Loratadine is about 97% bound to plasma proteins at the expected con-centrations (2.5 to 100 ng mL) after a therapeutic dose. Loratadine does not affect the plasma protein binding of warfarin and digoxin. The metabolite descarboethox, oral dine is 73% to 77% bound to plasma proteins (at 0.5 to 100 ng inL

Whole body autorad graphic studies in rats and monkeys, radiolabeled tissue de tributio studies in mice and rats, and in vivo radioligand studies. mice have shown that their oratadine nor its metabolites readily cross the blood-brain barrer. Radioligand binding studies with guinea pig pulmo-nary and brain H.-r. eptors indicate that there was preferential binding to peripheral versus central nervous system H,-receptors.

Clinical to a s of CLARITIN Tablets involved over 10 700 patients who re ceived either CLARITIN Tablets or another ant histamine and or placebo in doub e-b indirandomized controlled studies. In placebo-controlled trials, 10 mg = ce da = of CLARITIN Tablets was superior to placebo and similar to clemastine it mg BID) or tertenadine (60 mg BID) in effects on nasal and non-nasal symplems of allergic thinlis. In these studies, somnolence oc curred less tree—rity with CLARITIN Tablets than with clemastine and at about the same freq—ic—as terfenadine or placebo. In studies with CLARITIN Tablets It sel 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence. In a study in which CLARITIN Tablets were administered at 4 times the

clinical dose for 90 days, no clinically significant increase in the OTc was seen

INDICATIONS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite. descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the DTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole

Other drugs known to inhibit hepatic metabolism should be coadminis tered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHD-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood mphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding

occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. 8ecause animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxylorata-dine, pass easily into breast milk and achieve concentrations that are equivalient to plasmal levels with an AUC<sub>max</sub>/AUC<sub>max</sub> and to of 117 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug. taking into account the importance of the drug to the mother. Caution should

be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebocontrolled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months, duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo

REPDRTED ADVERSE EVENTS WITH AN INCIDENCE OF MDRE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS DEDCEMT DE DATIENTS DEDDOTINO

CAGCIAL DI L'ARICIALO NEL DIVING						
	LORATADINE 10 mg DD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg 8ID n = 536	TERFENADINE 60 mg BID n = 684		
Headache	12	11	8	8		
Somnotence	8	6	22	9		
Fat gue	4	3	10	2		
Dry Mouth	3	2	4	3		

Adverse event rates did not appear to differ significantly based on or race, although the number of non-white subjects was relatively In addition to those adverse events reported above, the followin events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased:

altered lacrimation, hypoesthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, ch rigors, fever, aggravated allergy, upper respiratory infection, angio edema

Cardiovascular System Hypotension, hypertension, palpitatio cope, tachycardia

Central and Peripheral Nervous System Hyperkinesia, blephar paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomitii lence, gastritis, constipation, diarrhea, altered taste, increased anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia

Psychiatric Anxiety, depression, agitation, insomnia, paroniria, impaired concentration, contusion, decreased libido, nervousness Reproductive System 8 reast pain, menorrhagia, dysmenorrhea, Respiratory System Nasal dryness, epistaxis, pharyngitis,

nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezir chospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, ritus, photosensitivity reaction, purpura. *Urinary System* Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been rarely during the marketing of loratadine: peripheral edema; abno patic function, including jaundice, hepatitis, and hepatic necrosis; seizures; breast enlargement; erythema multiforme; and anaphylax

DRUG ABUSE AND DEPENDENCE There is no information to indi abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache have ported with overdoses greater than 10 mg (40 to 180 mg). In the overdosage, general symptomatic and supportive measures shinstituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis

syrup), except in patients with impaired consciousness, followed by ministration of activated charcoal to absorb any remaining drug. If is unsuccessful, or contraindicated, gastric lavage should be pewith normal saline. Saline cathartics may also be of value for rapid of bowel contents. Loratadine is not eliminated by hemodialysis known if loratadine is eliminated by peritoneal dialysis

 $Dral\ LD_{so}$  values for loratadine were greater than 5000 mg/kg in mice. Doses as high as 10 times the recommended clinical doses no effects in rats, mice, and monkeys

DOSAGE AND ADMINISTRATION Adults and children 12 years of over. Dne 10 mg tablet daily on an empty stomach

In patients with liver failure, 10 mg every other day should be

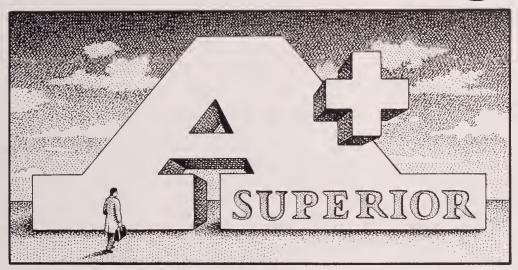
HDW SUPPLIED CLARITIN Tablets. 10 mg. white to off-white com tablets; impressed with the product identification number "458" side, and "CLARITIN 10" on the other; high density polyethylene pl tles of 100 (NDC 0085-0458-03). Also available, CLARITIN Unit-of-uages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-01 tablets (10 tablets per blister card) (NDC 0085-0458-05); and 10  $\times$ Unit Dose-Hospital Pack (NDC 0085-0458-04)

Protect Unit-of-Use packaging and Unit Dose-Hospital Pa excessive moisture. Store between 2° and 30°C (36° and 86°F)

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## MisHIN Project Grant Approved

ississippi Health Sciences Information Network (MisHIN) connects rural health practitioners to academic medicine and other state health sources.

With a recently approved \$1 million, three-year grant to the University of Mississippi Medical Center (UMC), funded through the National Library of Medicine (NLM), the state-of-the-art communication technologies at UMC's Rowland Medical Library will be upgraded and expanded to further allow state health care professionals and practitioners to access a wide variety of health information resources.

The network is designed to provide traditional library services by delivering information electronically anywhere in the state.

For U.S. Navy nurse Cdr. Deborah Carmen, currently completing her master's thesis, MisHIN has been a definite plus. She lives in Meridian, with a population of about 47,000, one public library and one community college library.

"It would be impossible to complete my thesis with the information available at the libraries here. I would have to travel to Hattiesburg or Jackson to get the data I need, but because of MisHIN, I don't. I can't even figure up the costs MisHIN has saved me," Carmen said. "I think this is the greatest thing to ever hit Mississippi. I wish other states had it."

At times when there were malfunctions in the system, Carmen said personnel at UMC were easily contacted and the problems were corrected in 20-30 minutes via telephone.

Small hospitals, primarily, use MisHIN for information purposes and to meet accreditation standards. The majority of subscribers are in rural areas or areas which have limited health sciences libraries.

Dr. Donald Ratliff, a Corinth physician, said with MisHIN, he saves money, keeps abreast of new medical procedures and updates and is able to have colleague consultations, without playing "telephone tag."

"It's been very beneficial to us rural doctors who don't have consultation readily available. Personally, it's helped me save a lot of money on phone calls—no longer having to track someone down for information. I can just send a message electronically and get a quick response. I really like that aspect,"

Dr. Ratliff said.

He also noted that in two recent patient cases, one involving a rattlesnake bite and the other a two-year-old who swallowed a watch battery, he has used MisHIN's software, Grateful MED, for information.

In the past, rural physicians have been particularly hindered by a lack of computer telecommunications in the office, a lack of computer literature search training, outdated medical books in the office and continuing medical education (CME) programs that are not convenient geographically, according to Ada Seltzer, Rowland Medical Library and MisHIN director.

For these reasons, a network like MisHIN has long been considered a necessity, Seltzer said.

"The lack of access to new health sciences information by health professionals and health care institutions throughout the state has been a concern of health science librarians and health professionals for several years," she said. "MisHIN has alleviated some of those concerns. Since its start, it has grown tremendously."

MisHIN began in 1989 as a fed-

erally-funded pilot program with a \$37,000 grant to the Medical Center from the NLM through the National Network of Libraries of Medicine Southern/Atlantic Regional Medical Library, headquartered at the University of Maryland at Baltimore Health Sciences Library. UMC currently finances the program, including costs of computer software, training and travel expenses.

There is no fee to subscribe, or for electronic-mail usage, computer software, software installation, onsite training or training at UMC, but patrons must pay costs for special services such as literature searches or to secure journal articles, books and other information from the five participating libraries.

Two types of software, Procomm and Grateful MED, are used by each member. The Procomm software provided dial access to the network. The Grateful Med software allows online searching for journal articles. Both give crucial information to health professionals who have no access to similar services nearby and to those who are geographically distant from the hospital system networks in the state.

Additionally featured is Loansome DOC which allows users to order copies of journal articles online from a library of their choice.

RoMeO, Rowland Medical Library's online catalog containing all the library's books and journal holdings, is available to each subscriber, as well as access to the Medical Library at the Veteran Affairs Medical Center in Biloxi, Fant Memorial Library at Mississippi University for Women in Columbus, W. B. Roberts Library at Delta State University in Cleveland, Mitchell Memorial Library at the School of Veterinary Medicine at Mississippi State University in

Starkville and Rowland Medical Library.

Various bulletin boards also are offered through MisHIN. Currently they include a list of MisHIN members with electronic mailboxes, phone numbers, MisHIN News, a calendar of professional meetings and continuing education activities in the state and the full text of National Institutes of Health Clinical Alerts.

The construction of permanent office facilities for MisHIN operations in the UMC Rowland Medical Library, one of the additions provided through the grant, are currently underway, and a plan to start MisHIN outside the original target area is being developed.

Seventeen additional state agen-

cies will participate, including the State Department of Health, state health professional associations, Mississippi Foundation for Medical Care, Methodist Hospital Library, Forrest General Hospital Library in Hattiesburg and the Department of Veteran Affairs Library, Jackson, and UMC Departments of Medicine and Surgery in the School of Medicine, and its Schools of Nursing and Dentistry.

"It's a rather unique coalition of health sciences information providers." said Jill Markgraf, network services librarian. "Any health professional in the state has access to the world of biomedical information that is obtained in a timely and cost-effective manner."





The President's Page MALLAN G. MORGAN, MD

#### **Grass Roots**

s we enter a new year for the Mississippi State Medical Association, I am reminded of (and challenged by) the leadership our organization has known over the years. Especially those leaders that I have known personally since I became active in MSMA during the mid 70's. To me, the leadership has been impressive, whether it came from a family practitioner in a small rural community or the most highly specialized physician from our largest metropolitan area. I cannot think of any in the past 15-20 years who has not had a positive impact on our organization.

And it's important to remember that these leaders have given heavily of their time and energies, as many continue to do, which has resulted in national respect and acclaim for many of our programs. But none of these have had any special training in the running of this type of organization. They have all come from the "grass roots" of MSMA. They started as delegates, and as they showed more interest in organized medicine, they were appointed tocommittees or elected to councils. From there they usually moved to one of the statewide offices and/or to the Board of Trustees. They put in their time and learned on the job. They are generally still active in their component societies where they got their start. What does this all mean? This means that the MSMA leader ship is not a "good ole' boy's club"; but rather, it is a grass roots organization run by it's members, for it's members and will continue to be so.

It is the component societies that supply our leadership and that make MSMA strong. We must continue to work toward strengthening these component societies so that, as in the past, they will continue to provide outstanding leaders in the future.

(Continued on page 136)

### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 5 MAY 1994

# **Sudden Sensory Neuro Hearing Loss**

Sudden sensory hearing loss is uncommon, but when it does occur it constitutes a medical emergency. Early recognition and prompt therapy for this clinical problem usually results in the return of hearing. My reason for discussing this subject editorially was stimulated by several cases over the past year and finding that few clinicians were aware of the clinical features, therapy, and need for immediate treatment.

Sudden sensory neuro hearing loss is accurately described by its title. It usually occurs in patients with normal or near normal hearing. It is very acute in onset and produces severe or total loss of hearing in the involved ear. There is no gradual decline in hearing acuity. At one moment the ear is functioning normally and seconds later there is a severe or total loss of hearing.

In one recent case the patient was shaving when he noted a sudden noise followed by an immediate severe hearing loss. Another patient was riding down the freeway when the same occurred while the third patient was working in his office.

The most significant aspect of four cases seen over the past year is that the two patients receiving immediate treatment had a return of hearing. The

two other patients who delayed getting an appropriate evaluation and therapy had no return of function.

Sudden sensory neuro hearing loss is usually secondary to acute vasospasms of the oochlear artery and results in acute ischemia. If treated within the first four to six hours there is a very good chance for recovery, where as delays of 12 hours or more usually results in permanent loss of hearing. Fortunately it is usually a unilateral problem. Treatment consist of an immediate stellate ganglion block for relief of the vasospasm on the involved side. If there has been more than six hours IV Lidocaine can be administered.

Physicians need to be more acutely aware of this problem. Although it is not extremely common, when it does occur the patient needs immediate management in order to retain the sensory function of hearing. Antibiotics and antihistamines are of no value. Usually a good clinical history will differentiate the sudden severe loss of hearing in one ear from a progressive loss associated with otitis media or other similar disorders. When suspected, patients should be immediately referred for management with great emphasis placed on the significance of obtaining that treatment within the first several hours.

Myron W. Lockey, MD Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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During the Legislative Conference in Jackson last January we met with several component society secretaries and presidents in the hope of exchanging ideas on improving the programs, increasing attendance, recruiting new members and disseminating information to the membership as to what is happening on the local, state, and national levels in (and to) medicine. For it is from these local society meetings that MSMA and eventually the AMA are built. I encourage every physician in the state to attend their medical society meetings, and even if you don't want to carry your participation any further than that, at least you will have the opportunity to have your voice heard and be able to learn what is happening on the state and national levels. For those that are interested, come to the annual state medical association meeting and attend the sessions, where your opinions can be heard and voiced by our representatives at the national level. It's a small step, but it may impact how we practice medicine in the years to come. This leads naturally to a discussion of health care reform, but more of that in another article.

I cannot end this President's Page without one other item. Dr. Don Q. Mitchell has led the Mississippi State Medical Association for the past year. It has been a busy, fast moving, and eventful year. Don worked with and on the Board of Trustees for many years as the Secretary-Treasurer and continues to serve as an AMA delegate with distinction, but he has truly exceeded himself this year. He has done an excellent job and spent many hours away from his practice. Dr. Mitchell deserves our appreciation and our congratulations. Thanks, Don Q., from all of us!

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#### A Call For Member's Opinions On Nurse Practitioners In the State Of Mississippi

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Lately, I've been wondering just why it is that the "powers that be" seem to be trying so hard to keep physicians from practicing medicine by placing almost insurmountable obstacles in our path and at the same time, crying out for more primary care doctors. On the other hand it seems to be getting all-too easy for non-MD's to set up and operate their own clinics and to earn higher fees for their services than physicians in private practice.

For the life of me, I don't understand the rationale behind this inequity.

The MSMA's Council on Medical Service is currently studying the concept of Nurse Practitioners and P.A.'s (Physician's Assistants), defining their roles and our relationship to them, and seeking an understanding of reasons for their rapid proliferation in independent practice on the Mississippi Health Care Scene.

An article in the Journal of Postgraduate Medicine, Sept.1, 1993 (page 23), the editorial "Your 'Family Doctor' May be a Nurse!" raised many questions and eyebrows among physicians. No one doubts that physicians and allied health practitioners (NP's, PA's) working together can achieve high quality care for

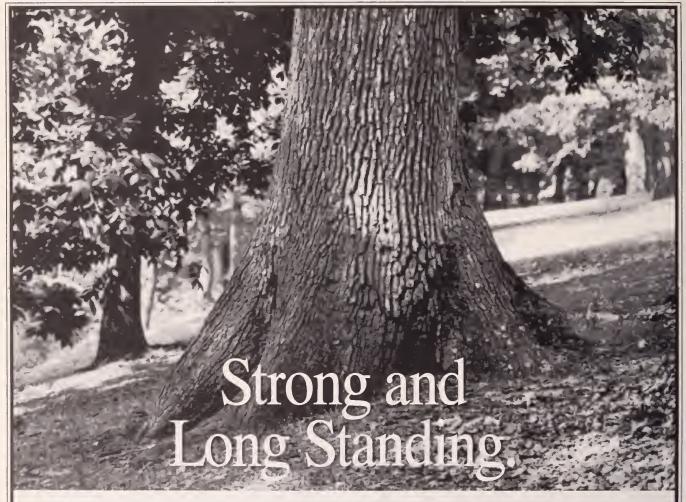
patients. Many of us do have reservations about a nurse or a PA being the sole provider of primary care

There is a core lobby of about 30 "nurse-specialist" organizations promoting expanded roles for nurses. They like to tout statistics that NP's can be educated with one-fifth the money and in one-fifth the time that it takes to produce a traditional physician. With this variation must come vast differences in the depth and scope of medical training.

Are there standardized national boards for determining the competence of NP's? If not, why not? How many different routes are there for becoming an NP? Quite simply there is much confusion on the roles of NP's and PA's in our health care system.

Please address your questions, comments and suggestions on this topic to the MSMA Council on Medical Service as we begin this important issue.

Very Sincerely,
Dwalia South, MD,
Chairman
Council on Medical Service



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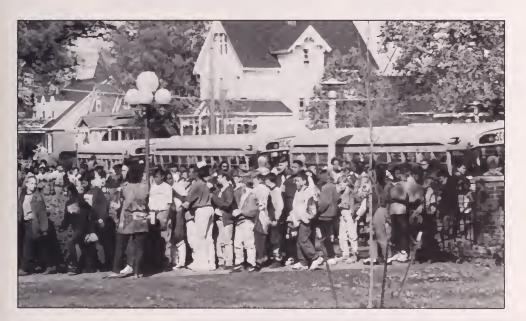
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overlooked by other companies.



#### **Medical Organization**

#### 6,000 Students Attend Health Choice 1994



School buses filled with students arrived in a long continuous line for the opening session of Health Choice 94.

Columbus area Alliance members welcomed students and teachers in record numbers to their second annual Health Choice Seminar.

Over 1600 students from Columbus public schools packed the auditorium on the MUW campus to hear motivational speaker Jevon Thompson talk about healthy lifestyle choices.

During the afternoon session more than 300 students at a local private school participated.



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Health Choice 94 was held in Jackson for the first time this year. Over 700 students participated and the Administrator of the Jackson Public Schools has already asked that the program be conducted next year for more students.

In addition to hearing motivational speaker, students in Jackson enjoyed a healthy lunch provided by local hospitals and participated in a Health Fair.

During the Health Fair students had their blood pressure checked and enjoyed some aerobic exercises.







In Hattiesburg Health Choice '94 was held at Bennett Auditorium on the University of Southern Mississippi Campus.

This is the fourth year Health Choice has been held in Hattiesburg.

Over 3,000 5th and 6th graders participated in two morning sessions.

#### The University of Mississippi Medical Center

#### Dr. Wallace Conerly Named Vice Chancellor and Dean

Dr. A. Wallace Conerly will become vice chancellor for health affairs and dean of the School of Medicine at the University of Mississippi Medical Center in Jackson on August 2.

University Chancellor R. Gerald Turner announced his appointment following approval by the Board of Trustees of State Institutions of Higher Learning on Thursday.

A member of the Medical Center faculty since 1973, Dr. Conerly has served as the assistant vice chancellor for health affairs since 1981.

"Dr. Conerly's exceptional experience as a health science campus administrator, his long tenure as a health professional educator and his background in both private practice and academic medicine give him the kind of credentials the Medical Center's chief executive officer must have," Chancellor Turner said. "He has been intricately involved in long range planning for the institution and in developing and implementing the \$109 million in expansion projects we currently have underway.

"We are in a time of great change in both health professional education and health care delivery in America. Dr. Conerly has the seasoned leadership skills the institution needs to meet the challenges we face. I am very pleased that he has accepted this appointment and look forward to work-



Dr. A. Wallace Conerly

ing with him on a day-to-day basis," he said.

Dr. Conerly will succeed Dr. Norman C. Nelson who is retiring on August 1. Dr. Nelson has been the Medical Center's vice chancellor for health affairs and medical school dean since July, 1973. His tenure of more than two decades is among the longest of any health sciences campus CEO in the country.

Associate professor of medicine and medical director of the Department of Respiratory Therapy in University Hospital, Dr. Conerly also served the health sciences campus as director of the Division of Continuing Health Professional Education from 1979 to 1993. Under his leadership, both the division's programs and participant number significantly increased.

A native of Tylertown, Dr. Conerly received the BS with hon-

ors in 1957 at Millsaps College. He earned the MD in 1960 at Tulane University and took his internship at the McLeod Infirmary at Florence, S.C., and U.S. Air Force School of Aerospace Medicine at Brooks Air Force Base, Texas. He did a fellowship in medicine in the section on Cardiology at Ochsner Foundation Hospital in New Orleans, then took a residency in medicine at the Medical Center. He was the institution's Mississippi Lung Association Fellow in Pulmonary Disease from 1972-

Dr. Conerly served in the U.S. Air Force for more than six years, as director of the Aerospace Medicine Division for the 3350th USAF Hospital at Moody AFB, Ga., from 1961-1963 and director of base medical services at Vance AFB, Okla., from 1963-1965. Recipient of the USAF Flight Surgeon of the Year Award in 1962, the USAF Commendation Medal in 1963, he was honorably discharged from the Air Force in 1966 at the rank of major.

Dr. Conerly is a fellow of the American College of Physicians and the American College of Chest Physicians. His professional memberships include the American Medical Association and Mississippi State Medical Association, Central Medical Society, American Academy of General Practice, Aerospace Medical Association, American and Mississippi Thoracic Societies, American Society of Internal Medicine, Association of American Medical Colleges and the Mississippi Academy of Sciences.

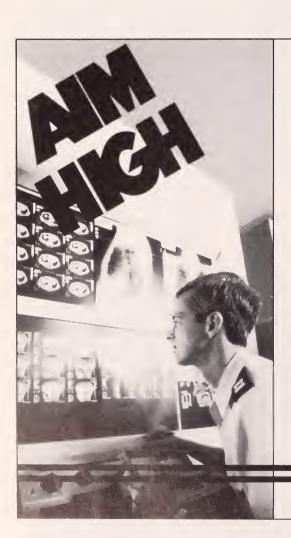
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Dr. Conerly is a former examiner and member of the Board of Trustees for the National Board of Respiratory Care and has served on the Mississippi State Medical Association Council on Medical Education, the Professional Education Committee of the American Heart Association, Mississippi Affiliate, and the Journal of Respiratory Diseases editorial review board.

He has been a consultant to the Joint Review Committee for Respiratory Therapy Education of the American Medical Association Council of Allied Health Education Accreditation since 1980. He was appointed as site visitor for the Southern Association of College and Schools in 1984 and for the Liaison Committee for Medical Education in 1988. He also is the state health contact for the

Southern Regional Education Board.

Dr. Conerly has served on the Board of Directors of the American Red Cross, Mississippi Chapter, and is currently serving on the board of the Capital Area United Way and the board of the Rotary Club of Jackson. He is married to the former Frances Bryan, and they have two sons, Albert Wallace, Jr., and Charles Franklin.



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#### University of Mississippi Of Mississippi Medical Center Friends Of Rowland Medical Library

Friends of Rowland Medical Library, a newly-organized support group for the University of Mississippi Medical Center (UMC) library, has elected officers for 1994-1995.

Dr. Robert Lewis, UMC professor of pathology, will serve as president; Jeanette Waits, professor of nursing, as vice-president and Marilyn Currier (Mrs. Robert) as secretary-treasurer.

Friends of Rowland Medical Library was organized to foster and support the programs, resources and facilities of UMC's library.

The group conducted its first membership drive during National Library Week - April 17-23. Membership is open to any person, firm, or members choose group, and dues are required annually, unless to become life-time supporters. Dues and contributions are tax deductible.

All members will receive a subscription to SOURCE, the Rowland Medical Library's quarterly newsletter and invitations to all special events sponsored by the library and the Medical Center Archives and History committee.

UMC's library was named in honor of the late Dr. Peter Rowland, who was a professor of pharmacology on the Oxford campus and primarily responsible for the library's establishment. Rowland Medical Library serves all schools and programs on the health sciences campus and is Mississippi's principal repository of health sciences information. It also functions as a resource library within the National Network of Libraries of Medicine, Southeastern/Atlantic Region.

All library operations are fully automated by the computer system. Rowland Medical Online (RoMeO) which provides access to the online catalog of library holdings and several bibliographic and reference data bases such as MED-LINE, CINAHL, HEALTH, and AMA FREIDA.

Rowland Medical Library is

part of the Medical Center's Verner Smith Holmes Learning Resource Center. It contains more than 202,267 items and receives 2,294 current periodicals and serial publications.

For more information or a brochure on "Friends" call UMC Public Relations at 984-1100. □



Friends of Rowland Medical Library Elect Officers-

Dr. Robert Lewis, UMC professor of pathology (second from right) is the first president of the support group. He is pictured with (1-r) Dorothy Morrison (Mrs. Francis), interim president, Marilyn Currier (Mrs. Robert), secretary-treasurer and Ada Seltzer, director of Rowland Medical Library. Jeanette Waits, UMC professor of nursing and elected vice-president, is not pictured. Friends will foster and support the programs, resources, and facilities of UMC's library.

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### "Summer Experience In Rural Health"

A newly-developed summer program at the University of Mississippi Medical Center will give sophomore and junior college students a rare rural medical experience at community health care facilities throughout the state.

"Summer Experience in Rural Health," an interdisciplinary, eightweek program, will be implemented in summer, 1995.

A total of \$270,427 in funding, for four summers, was recently awarded to UMC by the W. K. Kellogg Foundation.

If "Summer Experience in Rural Health" is a success, the Kellogg Foundation will possibly make it a national pilot program, according to Dr. Michael Bross, project director and director of the Community and Rural Medicine Program in UMC's Department of Family Medicine.

The summer program is geared toward minority and disadvantages students who are natives of rural communities, but any student with an acceptable grade point average and an interest in a health care field can apply. Those selected to participate will receive a stipend for the summer.

The program was developed by UMC's Department of Family Medicine and the Mississippi Primary Health Care Association, with Robert Pugh, executive director of the association, serving as network site director for the project. Coordinators hope to give students a positive, hands-on experience in a rural setting early in their collegiate careers to foster interest in returning to rural areas upon completion of their health professional education.

"There's such a shortage of rural health care personnel, "Dr. Bross said. "I think this program

is a great way to begin to combat the problem."

Personnel from the Mississippi Department of Health, the Office of Minority Students Affairs at UMC, Jackson State University, Tougaloo College, and community health centers across the state will take part in various aspects of the program.

Six of 21 Mississippi community health centers will take part during the first summer. At these sites, students will be matched with a program mentor within their field of interest. Mentors, typically the medical director or designee at the center, will serve as clinical role models and guides for explaining center procedures.

The students will get a general overview of all community health services available, but more emphasis will be placed on the student's specific areas of interest.

Students will observe and gain a better understanding of these areas: administration, family medicine, pharmacology, well-baby care, minor office surgery, laboratory, social services, x-ray technology, diabetic screening, patient education, preventive medicine, adolescent care, family planning, preventive dentistry, nursing, prenatal/maternity care, routine health, optometry, nutrition, ultrasonography, physical therapy, home health, audiology, mental health, adult care and blood pressure screening.

At the conclusion of the program, 60 students will have participated, including 10 the first summer, 14 the second; 16 the third and 20 the fourth.

Dr. Bross said he is optimistic that the program will be one of interest to many students.

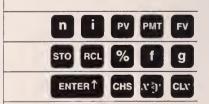
"We're excited and think it will be a good model for other institutions," he said. "I expect we will get many applications from students."

The W. K. Kellogg Foundation

was established in 1930 to "help people help themselves." As a private grantmaking foundation, it provides seed money to organizations and institutions that have identified problems and have designed constructive action programs aimed at solutions. A majority of the Foundation's grantmaking is focused on the areas of youth; leadership; philanthropy and volunteerism; community-based, problem focused health services; higher education; food systems; rural development; groundwater resources (in the Great Lakes area); and economic development (in Michigan). Programming priorities concentrate grants in the United States, Latin America and the Caribbean, and southern Africa.

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#### Dr. Leonard Fabian Dies

Dr. Leonard W. Fabian, first chairman of the Department of Anesthesiology at the University of Mississippi Medical Center, died of cancer at Barnes Hospital on Friday (March 25, 1994) in St. Louis, Missouri. He was 70.

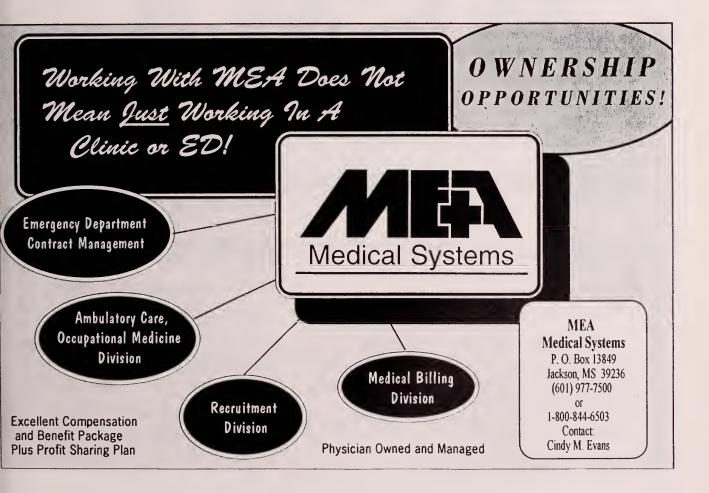
A native of Little Rock, Arkansas, Dr. Fabian earned his M.D. at the University of Arkansas and took his internship and residency there in anesthesiology. He served on the anesthesiology faculty at Duke from 1955 until 1958 and

was professor of anesthesiology and chairman of the department at the Medical center here from 1958 until 1971. He was on the Washington University School of Medicine faculty from 1971 until he retired last year.

A past chairman of the Board of Governors of the American College of Anesthesiologists, Dr. Fabian served for 14 years as associate editor of Clinical Anesthesia and associate editor of Survey of Anesthesiology. He was a con-

sultant on occupational health facilities for the Kennedy Space Center from 1968 through 1971 and was a member of the ground medical support team for the Apollo Manned Space Flights X through XVII.

Dr. Fabian included among his professional memberships the International Anesthesia Research Society, the Association of University Anesthetists, American Federation for Clinical Research and the American Heart Association.



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#### **New Members**

Braden, David S., Jackson. Born Tupelo, MS, July 5, 1958; MD, University of Mississippi School of Medicine, Jackson, MS, 1984; pediatric residency, same, 1984-87; pediatric cardiology fellowship, Medical College of Georgia, Augusta, GA, 1987-90; Elected by Central Medical Society.

Frazier, Randall P., Corinth. Born Pittsburg, PA, January 15, 1961; MD, Vanderbilt University School of Medicine, Nashville, TN, 1986; orthopaedic surgery residency, University of Tennessee School of Medicine, Memphis, TN, 1986-91; elected by Northeast Mississippi Medical Society.

Germann, Robert Earl, Gulfport. Born Reading, PA, October 1, 1945; MD, University of Gruxelles, Belgium, 1976; neurosurgery residency, Albert Einstein College of Medicine, New York, NY, 197782; elected by Coast Counties Medical Society.

Howard, Craig S., Hattiesburg. Born Louisville, KY, August 14, 1953; MD, University of Louisville School of Medicine, Louisville, KY, 1979; interned one year Medical University of South Carolina, Charleston, SC; radiology residency, University of Kentucky Medical Center, Lexington, KY, 1981-84; elected by South Mississippi Medical Society.

Leake, Lawrence A., Pascagoula. Born Hopewell, VA, July 17, 1957; MD, University of Virginia School of Medicine, Charlottesville, VA, 1984; one year internship, Greenville Hospital System, Greenville, SC; emergency medicine residency, Texas Tech University School of Medicine, El Paso, TX, 1987-90; elected by Singing River Medical Society.

Lehman, Thomas W., Gulfport. Born Gulfport, MS, April 11, 1951; MD, University of Mississippi School of Medicine, Jackson, MS, 1976; ob-gyn residency, same, 1978-81; elected by Coast Counties Medical Society.

Mattice, David F., Hattiesburg. Born September 19, 1963, Ottawa, Ontario, Canada; MD, University of Toronto Medical School, Canada, 1989; family practice residency, University of Ottawa, Ottawa General Hospital, Canada, 1989-91; elected by South Mississippi Medical Society.

McCarthy, Richard F., Hattiesburg. Born Lancaster, PA, December 11, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1978; residency in radiology, Medical College of Virginia, Richmond, VA 1979-82; MRI fellowship, Rush-Presbyterian,

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#### New Members / continued

St Lukes Medical Center, Chicago, IL, 1989-90; elected by South Mississippi Medical Society.

McDlll, Phillip Wade, Brookhaven. Born Anchorage, AK, May 7, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1983; interned one year Roanoke Memorial Hospital, Roanoke, VA; emergency medicine residency, Charity Hospital of New Orleans, LA, 1984-87; elected by South Central Medical Society.

Minetree, Thomas A., Greenville. Born Poplar Bluff, MO, July 7, 1931; MD, University of Arkansas Medical School, Little Rock, AR, 1959; radiology residency, same, 1960-63; elected by Delta Medical Society.

Molpus, William Mark, Hattiesburg. Born Hattiesburg, MS, November 14, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; diagnostic radiology residency, University of Arkansas for Medical Sciences, Little Rock, AR, 1988-92; neuroradiology fellowship, same, 1988-92; elected by South Mississippi Medical Society.

Rocconi, Paul M., Hattiesburg. Born Lake Village, AK, November 7, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1979; radiology residency, Naval Hospital, Oakland, CA, 1981-84; elected by South Mississippi Medical Society.

Schlessinger, Shirley D., Jackson. Born Dreux, France, March 28, 1959; MD, Louisiana State University School of Medicine, New Orleans, LA, 1985; internal medicine residency, University Medical Center, Jackson, MS, 1985-89; nephrology fellowship, University of Alabama School of Medicine, Birmingham, AL, 1990-92; transplant medicine fellowship, same, 1992-93; elected by Central Medical Society.

Sullivan, David W., Jackson. Born Meridian, MS, April 12, 1958; MD, University of Mississippi School

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of Medicine, Jackson, MS, 1980; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1987-90; elected by Central Medical Society.

Terracina, Joseph R., Greenville. Born Greenville, MS, May 5, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and residency, University of Texas Medical Branch, Galveston, TX, 1989-93; elected by Delta Medical Society.

#### **Deaths**

Caruthers, Samuel B., Memphis, TN. Born May 1, 1934, Duck Hill, MS; MD, Vanderbilt School of Medicine, Nashville, TN, 1928-30; interned one year, University of Virginia Hospitals, Nashville, TN; EENT, New York Postgraduate Hospital, New York, NY, 1932-34; died May 12, 1994, age 85.

Irby, Oscar W., Meridian. Born Stonewall, MS, January 3, 1928; MD, University of Mississippi School of Medicine, Jackson, MS, 1962; interned one year, Baptist Hospital, Nashville, TN; died March 23, 1994, age 66.

Simmons, Walter H., Jackson. Born Fordyce, AR, September 7, 1912; MD, Tulane University School of Medicine, New Orleans, LA, 1937; interned one year Roper Hospital, Charleston, SC; ob-gyn residency, same, 38-41; died April 22, 1994, age 81. \(\sigma\)

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychlatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, Increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence. <sup>1,3,4</sup> 1 tablet (5,4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

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#### References:

- 1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- 2. Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188 McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4,
- 4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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#### **Personals**

Thomas J. Anderson of Laurel has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Kate Aseme of Hattiesburg was appointed by Governor Kirk Fordice and has been confirmed by the Senate to the State Board of Health.

Lon F. Alexander, of Jackson has associated with Methodist Neuroscience Associates, 1828 Hospital Drive.

Robert E. Bailey, of Laurel announces the relocation of his practice in neurology to Rush Clinic 1800 12th Street, Meridian.

J. David Bullock announces the opening of the Sumrall Medical Center, specializing in family medicine, 1238 Highway 42, Sumrall.

Peter Casano has associated with T. A. Graves to the Gulf Coast for the practice of otolaryngology, 4500 Old Pass Road, Gulfport.

Jan T. Goff, of Tupelo announces an office relocation to 557 Eason Blvd., Suite D.

Paul E. Sheffield, of Jackson was recently named Methodist Medical Center's new Chief of Staff for 1994.

**Dwalia S. South** of Ripley has completed continuing medical education requirements to retain active

membership in the American Academy of Family Physicians.

Robert R. Smith of Jackson has associated with Methodist Neuroscience Associates, 1828 Hospital Drive.

J. Edward Ulmer has associated with the Immediate Care Clinic, 1710 14th Street, Meridian, MS for the practice of family medicine.

Winn Wallcott of Jackson has received his board certification in Allergy and Immunology.

Timothy E. Whittle, has associated with The Women's Clinic of Hattiesburg, PA, 1 Medical Boulevard, Hattiesburg.

## Physicians' Recognition Award

Four MSMA members were named recipients of the AMA Physicians Recognition Award in March 1994. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

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**VOLUME XXXV** 

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# We Agree.

Every state medical society, 64 medical specialty societies, and the American Medical Association agree that any health system reform legislation must contain the principles outlined in the letter below:

February 23, 1994

#### Dear Senator/Representative;

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals, and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians, and other providers.
- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined, and coordinated system that minimizes red tape for patients, physicians, and other providers. Furthermore, health system reform must leave medical decision-making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care
- Allow for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a \$250,000 cap on non-economic damages, limits on plaintiff attorneys' fees, and other measures that would minimize defensive medicine.

Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective, and needed health system reform.

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#### **Dateline**

#### Journal of the Mississippi State Medical Association Volume XXXV, Number 6

State Among Nation's Best In Measles Prevention Jackson, MS — Mississippi excels nationally in immunizing preschool children against measles, says a study published May 11, 1994 in the Journal of the American Medical Association.

More than 95 percent of 2-year-olds in some rural parts of the state have been immunized against the disease, compared with immunization rates below 70 percent in several larger cities, Dr. Sandor Feldman of the University of Mississippi Medical Center found. "In Mississippi, when it comes to immunization, we do things right," said Dr. Feldman, UMC chief of pediatric infectious diseases.

The U.S. Department of Health and Human Services aims through its Childhood Immunization Initiative to improve vaccines, disease monitoring systems and immunization rates and to cut vaccine costs.

About one-third of children under age 2 are not properly immunized nationwide. Statewide, Mississippi ranks better than the nation in measle immunization rates of 2-year-olds — 87 percent in the state to 82 percent nationally. Rates between black and white children are almost identical.

"We find these results surprising because in many ways, Mississippi is the rural counterpart of the inner city," Feldman said in the study. "It has a large black minority population (35 percent), and for the past several years it has ranked at or near the bottom on the nation's economic and educational hierarchies." The federal Centers for Disease Control and Prevention in Atlanta should limit any changes in immunization techniques under the initiative to areas that need improvement, Dr. Feldman said, "If it's not broke, don't fix it," he said.

Dr. Feldman's study credits the state Department of Health, especially the nurses in its clinics, for the success. He calls the department proactive and user-friendly in its efforts to get children immunized. The department gives about 80 percent of the vaccinations in the state. The Health Department does not require appointments for immunizations, sends cards or calls mothers to remind them of needed immunizations and charges a low fee.

Public health nurses randomly surveyed 2,109 children between May and September 1990 for this study, coauthored by Dr. Michael Andrew of UMC's preventive medicine department.

\* \* \*

For the fifth consecutive year, the Mississippi State Department of Health will conduct monthly statewide surveys on the health and safety practices of Mississippi people. The survey is part of the Behavioral Risk Factor Surveillance System, a program to gather, compare, and use information that measures a state's health related behaviors. This year's survey will collect new information about injury prevention, including information on water and firearm safety and the ways health care providers counsel

(continued)

State Safety Survey Conducted

their patients. Survey results help target health education activities to people with the greatest needs, said survey coordinator Ellen Jones, director of health promotion and education for the State Department of Health. Knowing about people's health and safety practices also helps health professionals identify better ways to reach those target audiences. Survey results will keep public health professionals posted on trends in health behaviors. Each month, surveyors telephone at least 130 adult Mississippians, asking questions about such health behaviors as smoking, seat belt use, child safety, and nutrition. The questions, Jones said, relate to preventable illness and death which are related to life-style. The random survey involves calls — which take about 10 minutes each — during the day, evening, and weekend hours to get an adequate, accurate sampling. The survey is anonymous and confidential.

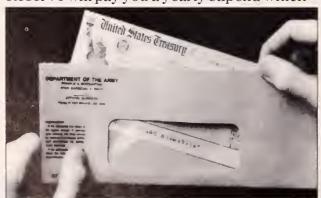
"We use the data with Healthy People 2000, a national campaign to improve America's health status before this century ends," Jones said. "We use that information for program planning and evaluation, and then we share the results with other state agencies, voluntary organizations, and community groups."

Jones said the Centers for Disease Control in Atlanta pays for the surveillance system. The Mississippi State Department of Health contracted with Southern Research Group to conduct the monthly surveys and train all interviewers. More information is available by calling Ellen Jones at 960-7499 or the office of Health Communications and Public Relations, 960-7667.

#### \* \*

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#### **Original Articles**

## Fatigue: A new approach to an old problem

David G. Hall, MD Shelia D. Sanders, MLT (ASCP) William H. Repiogle, PhD

amily physicians see many patients with complaints of fatigue. However, the literature on the subject is sparse, and few physicians have systematic work-ups for this common problem. Consequently, work-ups tend to focus on possible physical causes of fatigue, with unremarkable laboratory testing performed at additional cost to the patient.1-3 In many cases these tests do not reveal information helpful in forming a diagnosis. As a result, both physician and patient become frustrated with the search. The causative factor may never be found, or the diagnosis may be delayed for some time.

The differential diagnosis of chronic fatigue is extensive and varied, encompassing a host of organic causes ranging from endocrine disorders to infectious diseases. Fatigue may also have inorganic causes that are quite subtle.

Previous research regarding the fatigued patient has dealt primarily with the diagnostic labels appiled by physicians, rather than specific presenting symptoms of the fatigued patient. The purpose of the present study was to identify, based on presenting symptoms, gender, maritai status, and race, relatively homogenous sub-groups within a sample of fatigued patients that would aid in the diagnosis and treatment of the underlying disorder(s). Resuits of ciuster analysis suggested the presence of an Organic, Anxiety, Depression, and Mixed Anxiety/Depression group within the sample of 197 fatigued patients. Significant differences among these four groups were found on 13 of the 15 symptoms included in the cluster analysis. The proportion of maies, married patients, and white patients in the Organic Group was significantly greater than in the other three inorganic clusters as a whole. Positive or negative responses to these 13 symptoms can facilitate the diagnosis and treatment of the fatigued patient.

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Previous studies have focused only on physician's diagnoses and really have not given us any tools with which to distinguish the causes of fatigue. This study attempted to find a reasonable approach to the problem of fatigue, based on symptoms of patients with fatigue, which would divide patients into specific groups based on the constellation of symptoms. The following is a simple check-list which can be used.

Depressed mood	
Sleep disturbances	
Multiple somatic complaints	
Decreased appetite	
Headache	
Nervousness	
Anxiety	
Weight loss	
Work /School stress	
Weight gain	
Problems with children/parents	
Stress at home	
Race	
Marital status	
Gender	

ANXIETY GROUP		
HIGHER LEVELS OF	Lower Levels O	
Nervousness	Depression	
Anxiety	Weight gain	
Work/School stress	Home stress	
Headache		
Multiple somatic complaints		

DEPRESSION GROUP		
HIGHER LEVELS OF	Lower Levels O	
Depression	Nervousness	
Weight gain	Anxiety	
Stress at home	Work/School Stress	
Multiple somatic complaints	Decreased appetite	
	Weight loss	

ORGANIC GROUP		
All symptoms occur less often		
Relative lack of emotional, psychological and somatic complaints		
Significantly more lab abnormalities		
Lab testing would seem to be indicated for patients with few positive responses		
More likely to be male, white & married		

HIGHER LEVELS OF	
Anxiety	Sleep Disturbances
Depression	Problems with child/parents
Nervousness	
90 % of cases had an and sleep disturbanc	xicty, depression, nervousness

Berris and Rachlis4 review article estimated that the etiology of 50 percent of all fatigue cases is nonphysical. Similarly, Morrison<sup>1</sup> and Sugarman et al<sup>3</sup> reported that of patients who received a diagnosis of fatigue at the initial visit, 41 and 50 percent respectively, received a diagnosis that was primarily psychosocial in nature upon subsequent visits. Sugarman et al. noted, however, that fatigue is a symptom rather than a diagnosis. Accordingly, these studies may be considered a review of physician's diagnostic practices and only indirectly related to the symptoms of patients who present with fatigue.

A more cogent approach to elucidating the causes of fatigue is the investigation of the symptoms of patients presenting with fatigue rather than diagnostic labels applied by the physician. The purpose of the present study was to identify, based on symptoms, gender, marital status, and race, relatively homogenous sub-groups within a sample of fatigued patients that would aid in the diagnosis and treatment of the underlying disorder(s).

#### Method

Subjects consisted of 197 patients of a family practice residency training program. Eighty-two cases had received a diagnosis of fatigue and were found via a computer list of encounter diagnoses. An additional 115 cases which had not received a diagnosis of fatigue but presented with fatigue of greater than two weeks duration as the chief complaint were found by random selection of charts. Each chart was reviewed for the number and results of lab tests obtained during the course of treatment, age, gender, marital status, and race and for the presence or absence of 34 specific symptoms presented in

\* p < .01

Table 1. Each of the symptoms were coded as "O" if absent or "1" if present i.e. dummy coded.<sup>5</sup> Gender, marital status, and race were

also coded as dichotomous variables. Twenty-four of the symptoms were reported in previous research as being associated with fa-

	<b>FABLE</b>	I		
Number, percentage, and associated chi-square values for fatigue-related symptoms				
SYMPTOM	n	(%)	X <sup>2</sup>	
Multiple somatic complaints	97	(49.2)	30.35*	
Sleep disturbances	79	(40.1)	50.77*	
Depressed mood	65	(33.0)	74.71*	
Headache	53	(26.9)	35.89*	
Decreased appetite	53 52	(26.4)	19.85*	
Nervousness	44	(22.3)	40.94*	
Anxiety	41	(20.8)	76.70*	
Weight loss	41	(20.8)	39.03*	
Stress at home	34	(17.3)	24.26*	
Weight gain	27	(13.7)	22.00	
Muscle aches or cramps	25	(12.7)	5.86	
Fever	24	(12.2)	6.38	
Work/school stress	22	(11.2)	18.05*	
Problems with children	22	(11.2)	33.39*	
Financial problems	20	(10.2)	21.20	
Feeling tired	197	(100.0)	NA	_
Martial problems	19	(9.6)	NA	
Decreased libido	13	(6.6)	NA.	
Nausea/vomiting	13	(6.6)	NA	
Taking care of sick relative	12	(6.1)	NA.	
Dizziness	11	(5.6)	NA.	
Bereavement	11	(5.6)	NA.	
Dissatisfaction at work/school	7	(3.6)	NA.	
Dieting	7	(3.6)	NA	
Hectic life style	7	(3.6)	NA	
Boredom	6	(3.0)	NA	
Change in bowel habits	5	(2.5)	NA	
Arthralgias	3	(1.5)	NA	
Palpitations	3	(1.5)	NA	
Memory loss	2	(<1.0)	NA	
Confusion	1	(<1.0)	NA	
Night sweats	1	(<1.0)	NA	
Irritability	1	(<1.0)	NA	
Increased appetite	1	(<1.0)	NA	

tigue or lethargy.<sup>2</sup> An additional 10 symptoms were found during the chart review to have a concomitant association with the presentation of fatigue. Results of Discriminant and Chi-square analyses indicated that the two groups of 82 and 115 subjects did not differ on any of the above items. Accordingly, the two groups were combined for all subsequent analyses.

The mean age of the sample was 41.38 years (S.D.=18.92) with a range of 12 to 88 years. There were 39 males and 158 females. Seventy-seven patients were married and 120 patients were either single, separated, divorced, or widowed. Eighty-nine patients were black and 108 were white.

As can be noted in Table 1, sixteen of the original 34 symptoms were found to be present in at least 10% of the cases. The symptom "feeling tired" appeared in 100% of the cases and perforce would be unable to aid in identifying sub-groups within the sample of fatigued patients. Accordingly, the remaining 15 symptoms were retained for subsequent analysis.

Also, during the review process, each case was assigned by the authors (DGH & SDS) to either an Organic Class, Inorganic Class, or a Mixed Class. This assignment was based on the primary cause of fatigue found at initial or subsequent visits, according to the diagnoses of the primary physician.

#### Results

Cluster Analysis, a statistical technique which identifies relatively homogenous sub-groups within a patient population, was utilized in this study. The 15 symptoms noted above plus race, gender, and marital status were submitted to a cluster algorithm equivalent to McQueen's k-means<sup>6</sup> which resulted in the identification of four sub-groups within the original 197 cases. A

discriminant analysis (direct method)6 was then performed with the four groups identified by the cluster analysis serving as the categorical dependent variable. As noted by Hair, Anderson, and Tatham<sup>7</sup>, nonmetric variables may be utilized as independent variables in discriminant analysis if the variables are dummy coded. Accordingly, the 15 dummy coded symptoms and three demographic variables served as independent variables in the discriminant analysis. The Wilks' Lambda statistic and its associated chi-square value (Wilks' Lambda = .087, x2 =450.01, p.<.01) allowed rejection of the null hypothesis of equality of independent variable means. Thus, the results of the discriminant analysis indicated that, based on the 15 symptoms and three demographic variables, there were significant differences among the four sub-groups. The multivariate significance having been established, the individual independent variables that contributed to the overall significance of the discriminant analysis were examined by use of chi-square analysis. Data provided in Table 1 indicate the contribution to the overall significance level of each of the 15 symptoms. As can be noted, 13 of the 15 symptoms and 6 each of the three demographic variables were found to have a significant association with the four sub-groups identified by the cluster analysis. A descriptive label was then derived for each of the four groups based on the "profile" of each group's symptoms. These profiles suggested the presence of an Organic Group (n=122, 61.9%), Anxiety Group (n=11, 5.6%), Depression Group (n=38, 19.3%), and Mixed Anxiety-Depression Group (n=26, 13.2%). In assessing the demographic variables' contribution to the discriminant function, the Anxiety, Depression, and Mixed Anxiety-Depression Groups were collapsed into one inorganic group.

Demographic Characteristics of Organic and Inorganic Clusters			
Characteristic	Inorganic Clusters n (%)	Organic Clusters n (%)	X <sup>2</sup>
Gender			
Male	3 (7.7)	36 (92.3)	17.46*
Female	72 (45.6)	86 (54.4)	
Marital Status			
Married	19 (24.7)	58 (75.3)	8.71*
Unmarried	56 (46.7)	64 (53.3)	
Race			
Black	45 (50.6)	44 (49.4)	9.79*
White	30 (27.8)	78 (72.2)	
Γotal	75	122	

Data provided in Table 2 indicate that the Organic Cluster had a significantly greater proportion of male patients, married patients, and white patients than did the inorganic clusters as a whole.

Kruskal-Wallis One-way Analysis of Variance indicated that there was no difference among the four groups in terms of the number of lab tests ordered. (x2=2.43), p>.05, or the number of abnormal lab tests, (X2=4.96, p>.05). Analysis of variance also indicated that there were no significant differences between the four clusters in terms of age. F(3,193)=.17, p>.05. Means and standard deviations of the number of lab tests, abnormal lab tests and age by group can be found in Table

Results of Chi-square analysis also indicated a significant association (x2= 30.65, df=6, p<.01) between the four groups (clusters) and the three classes (Organic

Class, Inorganic Class, and Mixed Class) to which cases were assigned by the authors. Of the 63 cases assigned to the Organic Class, 54 or 85. 7% appeared in the Organic Group (cluster). An additional 17 or 56. 7% of the cases assigned to the Mixed Class also appeared in the Organic Group.

#### Discussion

Fatigue is a common symptom which often presents a diagnostic dilemma for the physician. The purpose of this study was to identify, based on symptoms and three demographic variables, specific subgroups within a sample of fatigued patients in order to facilitate the diagnosis and treatment of the underlying disorder. Four distinct groups were found and labeled Organic, Anxiety, Depression and Mixed-Anxiety Depression.

The Organic Group was unique

in that none of the 15 symptoms occurred more often than in the other three clusters. This represents a relative lack of emotional, psychological, and somatic complaints among this group. In addition, the proportion of males, married patients, and white patients in the Organic Group was significantly greater than in the other three inorganic clusters as a whole.

The Anxiety Group showed high levels of nervousness, anxiety, headache, multiple somatic complaints, and financial problems. Conversely, this group tended to be low depression. Treatment would seem to be related toward the reduction of anxiety by psychological counseling, relaxation techniques, and perhaps anxiolytics.

The Depression Group consisted of patients with higher levels of depression, weight gain, multiple somatic complaints, problems with children, and headaches. They

Means and Standard Deviations by cluster of groups of Number of Lab Tests,  Number of Abnormal Lab Test, and Age				
Lab Test				
x	1.44	.90	1.18	1.26
S.D.	1.44	1.51	1.22	1.28
Abnormal Lab Test				
x	.58	.45	.47	.19
S.D.	.92	.68	.68	.49
Age -				
x	40.75	44.36	42.47	41.5
S.D.	20.19	21.77	17.89	12.69

tended to be lower, however, in nervousness, anxiety, work stress and financial problems. Conventional treatment of depression would seem to be indicated in these cases for resolution of fatigue.

The Mixed Anxiety-Depression Group had higher levels of anxiety, nervousness, and depression. This group was also characterized by higher levels of work/school stress, problems with children or parents, weight loss, and decreased appetite. A chart review showed that these patients tended to have previous psychiatric diagnoses of personality disorders, neuroses, or psychoses. More intense psychological testing or psychiatric care would probably be needed in these cases for the resolution of fatigue and its causes in these cases.

A significant association was found between the Organic, Inorganic, and Mixed Classes assigned by the authors according to subsequent diagnoses, and the four above mentioned cluster groups. Inspection of the data supports the supposition that cases in the Organic Group consisted of those cases in which fatigue appeared to be organic in nature based on subsequent diagnoses, and could thus be identified by a paucity of symptoms on history. Similarly, cases in the Anxiety, Depression and Mixed Anxiety-Depression Groups, identified by their specific constellation of symptoms, were primarily those in which fatigue appeared to have an inorganic cause based on subsequent diagnoses.

Results of this study suggest that sub-groups within a sample of fatigued patients can be found using these 13 symptoms and three demographic variables. Placement into these sub-groups according to the patients' history can facilitate their diagnosis and treatment. This supports Morrison's suggestion that emphasis should be placed on the history and physical examination

while laboratory testing can be limited. This approach to the problem of fatigue, based on positive or negative responses to specific symptoms, can quickly differentiate patients with a probable organic etiology, who will require additional laboratory testing, from those that appear to have an inorganic basis, with more positive findings on history. If a patient fits clearly into one of the three inorganic groups, then treatment can be initiated to alleviate the cause and lessen fatigue. However, if a patient has symptoms of two or more of the inorganic groups, additional psychological assessment may be needed.

Some cases may present a confusing picture, with a few positive symptoms, but not fitting clearly into any of the four groups. This may represent multiple causes of fatigue or the failure of the patient to recognize or report their symptoms accurately. These patients require additional laboratory testing as well as psychological assessment to elicit the causes of fatigue.

This approach to the problem of fatigue, while not intended as an absolute screening mechanism, provides a much needed tool for the physician faced with this evaluation.

Replication of this retrospective study followed by prospective studies, however, will be needed to further evaluate the utility of this approach.

Fatigued patients present with a constellation of symptoms which may be both psychological and physical in nature. The physician who competently attends to each of these areas of concern provides total care for the patient.

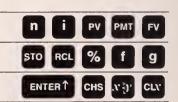
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#### **Special Articles**

#### Address of the President

r. Speaker, my medical colleagues, and especially our distinguished colleague, AMA President-elect Dr. Bob McAfee, my family and guests.

It has been a privilege to serve as the 125th President of the Mississippi State Medical Association. This privilege has only re-enforced my belief in the quality of physicians and spouses that we have in our MSMA.

Because of the dedication and unselfish support of my partners, and the staff of the Mississippi Asthma and Allergy Clinic, I have been able to devote the time and energy necessary to carry out the duties of this office.

To you - Faser, Bernard, Jim, Winn and Pat - thanks! I will be back in the office soon!

To the Board of Trustees, the officers, and the Alliance, my sincere gratitude for your never ending partnership in keeping our MSMA on the right track.

I have used a good many sport analogies this year, and have learned that we are supported by a real first team ..... The MSMA staff.

They have organized an outstanding program both education-



Don Q. Mitchell, MD

ally and socially for this annual session.

To the staff, Charlie, Bill, Ginger, Robert, Barbara, Jackie, Jennifer, Lora and Dona -- thank you for your expertise and especially your friendship.

To my family, I appreciate all of you being here -- I always know that you are with me -- I love all of you.

This year, one of my favorite sports personalities for quotations has been Yogi Berra. Yogi once said... "You've got to be careful if you don't know where you are going ... because you might not get there." I thought about that one when I was preparing this speech. To see where we are going I went back to our MSMA Constitution and Bylaws. Probably not many of us have ever taken the time to carefully read our Constitution and I don't intend to read it all to you today either. However, it is clear that the charges in this document continue to be relevant and necessary today.

This past year, we have concentrated our efforts, whether consciously or not, on fulfilling two key charges set forth in the constitution.

They can be summed up in a few words. This association should: 1) find ways to improve the health of Mississippi residents and 2) reach a consensus as a group on how best to deal with the problems of practicing medicine.

In the year to come, these two areas must continue to be in the forefront of our activities. In addition, we must concentrate our efforts on two more of the constitution's charges:

Ensuring just medical laws

and

Unifying as an organization.

Now lets look at where we are going on improving health.

The Constitution says, "The association should become more useful to the public in the prevention and care of disease." As individuals, we strive to care for our patients every day. After all, that is why we each chose to enter this profession.

The challenge for us as individuals who comprise this organization is to fulfill this mission as a group. It is a mission that we must take quite seriously. As we all are aware, many Mississippians have a lack of fundamental knowledge about public health and the impact of life-style on the overall state of individual health. This lack of knowledge translates into Mississippi having:

- one of the highest infant mortality rates
- one of the highest percentage of births to teenagers
- one of the highest rates of high blood pressure and
- one of the highest rates of STDs in the country.

This give us opportunities to work together as an organization to inform Mississippi's residents.

Thanks to the dedication and hard work of our MSMA Alliance, we have been able to successfully meet this challenge with the Health Choice program.

Health Choice's creators, which included one of my predecessors, Dr. J. Edward Hill, set out to fill the health education void in our schools by teaching early teenagers about health, nutrition, and exercise. In day-long seminars, students have the opportunity to listen to a nationally recognized motivational speaker, interact with one another and health care professionals in question and answer sessions and small group discussions, par-

ticipate in a health fair, work out in exercise programs and be energized by healthy foods and refreshments throughout the day.

Since 1991, with 95 Junior and Senior high students participating in the program in Hattiesburg -- we have grown by leaps and bounds. This year 6,000 students in Hattiesburg, Columbus and Jackson were Health Choice graduates.

And that number will only continue to grow. In addition, efforts are being made to expand to more cities throughout the state.

The Alliance made this program a success. They combined:

- · skills and expertise
- an ability to look at the problem of the lack of health education in our schools and to create innovative solutions to combat the deficiency
- · a willingness to serve; and
- a commitment to work with other organizations within the state to implement the program.

This year and in the year to come, we need to continue in our efforts to bring the Health Choice message to every child in Mississippi. In order to do this, we need to designate a full-time MSMA staff person to carry out this <u>crucial</u> responsibility.

At the same time, we should be looking for new ways to serve our patients. Some of the avenues available for us to do so are Governor Fordice's Health Care Commission health education proposals, which were enacted by the legislature this year.

Our association should actively participate in the development and implementation of these programs. Again, by providing skills, expertise, innovative solutions, a willingness to serve and a commitment to work with other organizations in the state, we can continue to fulfill the mission of improving the health of Mississippians.

This year has been one where we have had to reach a consensus on how to best address the changing medical world. Our constitution states that we should "guard and foster (physician's opinion) in regard to the great problems of medicine".

In order to fulfill this charge, the association must represent the majority views of its members in addressing the problems associated with the practice of medicine. No problem is more ominous or pressing than preserving physician autonomy and our ability to maintain control over the delivery of care to our patients.

Last year, this House of Delegates had the foresight to address that problem. It adopted the recommendation of the Council of Past Presidents and legally organized a physician-directed and controlled entity that could preserve the private practice of medicine while competing successfully in a growing managed care market.

As a result, in the past twelve months, we have moved aggressively to organize the Mississippi Physicians Care Network or MPCN.

MPCN, a wholly-owned subsidiary of our Mississippi State Medical Association, is a statewide risk-sharing PPO that will contract directly with self-funded employers to provide high quality, cost-predictable health care to employees. It is the only statewide, providerowned and directed managed care plan in Mississippi.

Today, over half of our actively practicing members have signed participation agreements with MPCN.

Furthermore, ACMG, Inc., our consultants and the company that will operate the network, has opened an office in Jackson. Their local marketing director is working diligently to inform self-funded employers about the opportunities that MPCN provides.

As a result, we have already met with several self-funded employers and are confident that within the next few weeks the first of many contracts will be signed.

MPCN has become a reality.

It is our last best hope of retaining control over the delivery of care to our patients. Without it, we will turn over the managed care market to insurance companies and large vertically-integrated systems. Our patients will lose, we will lose our autonomy and control over the system and, in turn, our society will lose.

I urge those of you who have not signed up with MPCN to do so. In addition, I recommend that we intensify our efforts to make the MPCN the best provider of physician-directed, high quality, costpredictable care in this state.

In 1993-94, the MSMA has shown strong leadership on providing health education and strong leadership in developing the MPCN program. In the year to come we must also show strong leadership, in the *political arena*.

Our constitution states that the association should ensure the "enactment and enforcement of just medical laws."

You should have all found a brochure on your chair. This brochure describes a new fund raising initiative our Mississippi Medical Political Action Committee is launching to correct the imbalance that has existed in the election of trial judges in Mississippi. As the brochure appropriately states, "Now is the time to balance the scales of justice."

During the last few years the State Supreme Court has consciously eroded many of the traditional defenses that were available to us in medical malpractice cases:

- We no longer have an effective statute of limitations
- non-physicians can testify as experts

- liability for negligence is wide open
- physician employees at the University Medical Center, State Department of Health and other state institutions have no qualified immunity from liability for their discretionary actions; and
- we have a standard of informed consent that is difficult to meet and in essence requires a physician to videotape the consent discussion with the patient in order to provide an adequate defense in the event a suit is later filed.

The year's elections for the Mississippi Supreme Court and the new Mississippi Court of Appeals could determine the fate of the medical liability climate for years to come.

It is imperative that medicine, together with other business, industry and health groups, actively support judicial candidates who will bring a sense of fairness and balance to liability case decisions.

The MMPAC brochure describing the Fund for Judicial Fairness will be sent to all MSMA members in the next few days. I urge you to solicit the involvement and support of your colleagues in this very important effort.

Finally, the theme that I have used throughout the year in speeches, in the journal and in my travels. It's never been more important that it is today and will only increase in importance tomorrow. UNITY.... UNITY.... UNITY....

The constitution states "that the purpose of this association shail be to federate and bring into one compact organization the entire medical profession of the state of Mississippi and to unite with similar organizations in other states to form the American Medical Association."

I am sure you are all aware that a resolution will be presented at

this annual session to repeal our Unified Membership Requirement. I urge you to listen to both sides of this issue and weigh the points carefully before making your decision.

Recently, our MSMA sent a survey out to 350 non-members asking why they didn't belong to the Association -- only 80 responded that they would join if we de-unified.

There are two sides to this issue. On one hand, our MSMA is one of only 5 unified state organizations. On the other hand, we as delegates must decide if de-unifying would actually aid in the expansion of our membership.

Is 80 out of 350 really worth it?

These issues and other issues are vital to the growth and the future of our MSMA. Granted, we all understand that there will be disagreements, struggles, and conflicts along the way. However, if we splinter, if we break apart, if we avoid seeing each other eyeto-eye on every issue -- we will all pay the price - our patients, the profession and our country. We must forge a consensus and thereafter all speak with the same voice.

I leave this office once again emphasizing the "WALT" Principle.

Let us all Walk -- Act -- Look --- and Talk Like doctors. As we go forward into the future of Mississippi Medicine in the pursuit of quality, affordable health care for all, let us go with a unity of purpose and the dignity of compassion.

God bless you all. Thank you.□

# Remarks of the Speaker

H. Vann Craig, MD

I know I'm preaching to the choir, but let me give you some facts and figures that you can use to persuade those who say the cost of belonging to MSMA and the AMA is too high!

It really pains me to write that check for \$1000.00 each December or January to pay my dues to the local Medical society, MSMA, AMA, AMPAC-MMPAC, and my wife's state and national Alliance dues. I have trouble gripping the pen and almost get writers cramp! There are many things that I would rather do with that money. I could go to the "boats" in Natchez or Vicksburg and have a really good time at Roulette or Craps. Or I could purchase one or two nice Gendai-to Japanese swords that I enjoy collecting — as long as my wife, Elizabeth, doesn't find out about it. Women just do not understand the fascination that men have about weapons.

We are pressed in the "business" of medicine between rising cost of practice and decreasing reimbursements from patients and third parties, we must look to the bottom line of the page to see if we are making any progress. I think we are. By belonging to our Fed-

eration, our dues may be free or we may actually make money by utilizing the programs that are provided by MSMA.

Let's take an example of an incorporated 38 year old Family Practitioner with four other employees — a receptionist, a bookkeeper insurance clerk, a Girl Friday - Nurse, and a janitor. With five employees, you are required to carry Worker's Compensation Insurance. If you purchase this insurance on the open market, you will pay an annual premium of \$995.00. If, on the other hand, you are smart and purchase your insurance from MPIC, it will cost you \$755.00, a savings of \$240.00.

Health insurance is available from MSMA Benefit Plan and Trust which, by the way, is doing very well. We now insure 8500 lives and just went through an intensive scrutiny by the Department of Labor with flying colors. We continue to be competitive and offer rates — comparing apples to apples — of 10 to 15% below market. A good employer should offer health insurance to employees. This group would pay \$735.00 monthly or \$8820.00 annually on the open market and \$537.30 monthly or

\$6447.60 from MSMA BP&T. A savings of \$2372.40. That, by the way, is the low bid. The other one was a savings of \$5200.00.

Disability insurance is available as a pass through from Benefit Plan and Trust. My own savings when I changed from commercial rates to our Plan was \$400.00 a year. This physician's savings covering self only was \$464.00.

Everyone has to fill out insurance forms. Even with electronic filing for Medicare, Medicaid, and some commercial companies, hard copies have to be generated. A busy physician's office will file 140 to 150 hard copies a week! Conservatively 7000 a year. MSMA sells HCFA 1500's for \$38.00/1000 to members and offers them to nonmembers for \$48.00. Let us assume the non-member isn't too smart and doesn't know about MSMA's insurance forms and purchases them from a well known commercial source of physicians office supplies for \$108.00/1000. \$108.00 less \$38.00 is \$70.00 times 7 (thousand) equals \$490.00.

Because Mississippi is a unified state, we are given an extra delegate and alternate delegate to the AMA. We also receive a 10%

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rebate on AMA dues. That's a check for \$43.00.

So far this represents a total of \$3609.40 in SAVINGS to MEMBERS and does not include practice management seminars, supplemental cancer insurance, services of the executive planning group, or the wonderful camaraderie of this annual session.

Let's all push the Member get a Member program and when you are told "I can't afford to pay all those dues". Use these figures and point out, "I don't understand how you can afford NOT to be a member of MSMA/AMA". We are the only game in town that represents the interests of all physicians. Compromise is the name of the game

of politics, and we may have to make some compromises before all this is through. Politics is like sausage. If you like the finished product, you probably should not watch it being made. These days we must all hang together or we will all hang separately and, I might add, twist slowly in the wind.



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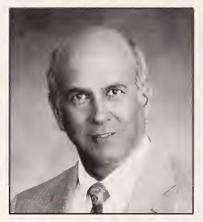
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The President's Page MALLAN G. MORGAN, MD

## There Is A Lott To The Lott Health Care Bill

ississippi Physicians and health care recipients should be proud of the bill (S-1533 and H-3080) that has been proposed by our Senator Trent Lott in collaboration with Representative Michel of Illinois. Senator Lott's bill addresses most of the problems of our health care system in a reasonable and cost conscious manner and yet doesn't tamper with the areas of health care that most would agree are working well.

The Affordable Health Care Now Act of 1993 as proposed by Senator Lott addresses the problems of improved access by requiring employers to make available health care benefit plans to their employees but not necessarily to pay for them. There would be a limit on pre-existing condition restrictions and therefore an end to "job-lock". This bill would reform the health insurance marketplace by requiring insurance companies to insure all employees of a business who wished to be covered for acute and preventative care. There is consideration for a "Medisave Plan", limits on premiums, and the establishment of reinsurance pools. Senator Lott has also made provisions for group purchase programs and tax deductions for health insurance. His plan tackles the community and migrant health care problems. Delivery of care to rural areas and the Medicaid population are important additional requirements.

Tort reform is developed with a dispute resolution process, a cap on non-economic damages, a requirement that any punitive damage awards go to the State (not the plaintiff or his/her attorney), limits on contingency fees, periodic payments of any awards to the plaintiff, uniform statute of limitations and a requirement that a losing plaintiff pay the defendants' legal fees. There is more in the Lott bill such as requiring standardiza-

(Continued on page 172)

# **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 6 JUNE 1994

### "Patient Protection Act"

On May 23, the AMA held a news conference in Washington D.C. to announce its new "Patient Protection Act". This legislation would require insurance companies to give patients a full explanation of how their insurance plan's provisions affect them.

The major provisions of the Patient Protection Act cover four areas:

- Patient Freedom of Choice. The Act would require that patients be offered the choice of three insurance options an HMO or PPO; a traditional insurance plan (with copays and deductibles); and a benefit payment schedule. The Act would also give patients a yearly opportunity to choose a point of service option. This option, available for an added premium, provides coverage even if the patient selects a physician outside the insurance network or plan.
- Disclosure of Restrictive Insurance Policies

   Patients would receive more complete and easily
  understandable information about policies that may
  restrict access to medical services.

Insurance companies would have to describe — in simple terms — which services are covered and excluded; prior authorization or other utilization review requirements; financial incentives for health professionals to withhold or limit services; and restric-

tions on referrals to medical specialists. Insurers would have to disclose the percentage of premium dollars spent on direct patient care services, as well as patient satisfaction data.

- Physician Selection Criteria To expand patient choice of physicians and protect against arbitrary exclusions, the Act would require insurance companies to disclose physician selection criteria. An insurance plan could not terminate a physician contract without cause, and would have to tell applicants all reasons for termination of a contract. Physicians would also be assured due process rights for adverse actions by insurers.
- Utilization Review Safeguards The Act would require advance disclosure of utilization review screening criteria. Medical policies governing coverage and payment would have to be based on sound clinical and scientific data rather than the financial bottom line.

Participating physicians would have a formal mechanism for input on setting insurance plan policies governing credentialing, coverage, quality and utilization review policies. Patients and physicians would no longer have to wait for days to get prior approval for medically necessary services.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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#### MISSISSIPPI STATE MEDICAL ASSOCIATION

# **Membership Benefits**

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

#### MEMBERSHIP HOTLINE

The MSMA provides a toll free WATS for any member to call to inquire about programs and policies of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

#### LIAISON SERVICES

MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

#### **HEALTH INSURANCE**

MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

#### **BUSINESS AND PERSONAL INSURANCE**

The MS Physicians Insurance Company (MPIC) in cooperation with MSMA offers a wide range of insurance for members of the association. MPIC has a Board of Directors appointed by MSMA composed entirely of practicing physicians who seek to identify the special insurance needs of physicians. For further information contact Jennifer Jones at MPIC.

#### PRACTICE MANAGEMENT

Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

#### **DEBT COLLECTION SERVICE**

Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call Robert Kidd at MSMA.

#### FINANCIAL/RETIREMENT PLANNING

MSMA members by virtue of their membership in the AMA are eligible to participate in AMA Investment Advisors, Inc. This wholly owned investment subsidiary of the AMA offers a wide range of investment opportunities tailored specifically for physicians. For further information call AMA Advisers.

#### MEDICAL MALPRACTICE INSURANCE

The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. More than 1700 Mississippi physicians are currently insured by MACM and extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

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tion and electronic submission of claims, anti-fraud provisions and the removal of impediments in current anti-trust laws to negotiation of fees.

I realize that I have given you a laundry list of the provisions in Senator Lott's bill but, believe it or not, this has only touched the surface. There is a great deal more in his bill which would be agreeable to most of the medical community. There are a few things in the bill, like air ambulances for rural hospitals, that at least in our experience have not been cost effective. Namely because in most cases the turn around time for an air ambulance from a large city is the same or greater than the time it takes for a direct trip from a rural area to the city. This money might be better spent on the purchase of more traditional ambulances for the rural hospitals. But these are minor considerations that I hope Senator Lott and his legislative assistants will discuss with the medical community as his bill is refined.

As everyone who watches congress is saying, some

kind of health care system reform bill with probably be passed this fall. Senator Trent Lott has come up with a conservative, well reasoned and workable health care plan. Unfortunately, these last three adjectives may spell doom for his plan in the current political atmosphere in Washington. None the less, his plan (developed with the help of his legislative assistant for health care, Ms. Terry Thames) provides the best answer to the health care "crisis" that I have seen thus far. This plan could indeed improve our country's health care delivery and financing. The fear that this bill is so reasonable that it will never pass does nothing to take away from the concern and the hard work that Senator Lott and his staff have put into The Affordable Health Care Now Act. They deserve our appreciation, and a pat on the back by Mississippi physicians would not only be appropriate but also well deserved.

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# **Medical Organization**

# **MSMA 126th Annual Session**



Mallan G. Morgan, MD, of Natchez, center, was installed as 1994-95 MSMA President during the closing session of the MSMA House of Delegates on Sunday, May 15. D. Stanley Hartness, MD, of Kosciusko, right, was named president-elect. Don Q. Mitchell, MD, of Jackson, left, is immediate past president of the Association.

# Dr. Morgan Installed as Association President; Dr. Hartness Named President-Elect

Dr. Mallan G. Morgan of Natchez was installed as 1994-95 president of the MSMA and Dr. D. Stanley Hartness of Kosciusko was named president-elect during the closing session of the House of Delegates on Sunday, May 15, 1994.

Dr. Morgan has served the Association as Chairman and Vice Chairman of the Board of Trustees and as an alternate delegate to

the American Medical Association.

Dr. Morgan is in the private practice of cardiology and internal medicine in Natchez. He is a member of numerous professional organizations including the American College of Physicians, the American Society of Internal Medicine, the American Heart Association and the Homochitto Valley Medical Society of which he has

served as both president and vice president.

Dr. Hartness is a family physician practicing in Kosciusko. He has served the association as Secretary-Treasurer, a member of the Board of Trustees and as a member and Chairman of the Council on Public Information. He is also a past president of the Mississippi Academy of Family Physicians.

# **Elected Officers, Board** and Council Members

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R. E. Frothingham, MD, Greenville



Members of Homochitto Valley Medical Society escorted Dr. Morgan to the podium for his installation as president.



Dr. Eric Lindstrom, left, Chairman of the Board administered the oath of office to Dr. Morgan, right, as Charles Mathews, MSMS Executive Director, held the Bible.



Dr. Morgan, right, presented Dr. Mitchell, left, his past presidents' pen.

# Actions of the House of Delegates 126th Annual Session, May 11-15, 1994

MSMA's House of Delegates acted on a broad range of reports from the Board of Trustees and MSMA's Councils, as well as resolutions. Delegates elected by their component societies participated in the House of Delegates and took the following actions:

- Acknowledged and commended formation of the MS Physicians Care Network (MPCN) in accordance with action by the House of Delegates at the 1993 Annual Session.
  - MPCN now begins its second organizational phase the marketing of the network to Mississippi employers.
- Went on record without a dissenting vote to continue unified membership with the AMA
- Noted that a new and intermediate judicial system would be established in Mississippi and urged the membership to participate in local elections to implement the system.
- Directed that the association closely monitor the development of a plan to establish a

state Health Financing Authority combining Medicaid and public employees in a health benefits purchasing pool — the plan will be presented to the 1995 Mississippi Legislature.

- Supported enactment of a comprehensive school health education program and directed that the association and the MSMA Alliance renew efforts to sponsor health seminars for teenagers and to have members serve as local school health education advisors.
- Directed that a study be done to determine the feasibility of the association sponsoring an "Any Willing Provider" law in the 1995 regular session of the Mississippi Legislature.
- Urged all health benefit plans to include as a minimum the preventive health services proposed in the AMA's standard benefits package and such other preventive health services as are beneficial, cost effective and affordable.
- Directed that the association conduct annual sessions in the regional area of the MSMA president's residence based upon the availability of ad-

equate convention facilities.

- Commended the Speaker of the house of Delegates for a report citing the economic benefits of MSMA membership and directed that the report be publicized to the membership.
- Endorsed a program presenting medical socioeconomic topics at annual sessions of the association and urged state specialty societies to conduct scientific programs concurrently with the annual session.
- Commended an informational program for UMC medical students and residents presented by Dr. Robert E. McAfee, President-elect of the AMA, and urged that a similar program be presented annually.
- Presented the 1994 MSMA Community Service Award to Dr. Robert Lee Giffin of Vicksburg.



AMA President-Elect Dr. Robert E. McAfee and Drs. Candace Keller and George McGee enjoyed the MSMA President's Reception held at the MS Agricultural and Forrestry Museum. Over 300 MSMA members and guests enjoyed the evenings activities.

During the President's Reception guests had the opportunity to try their talents at country western line dancing.

Members of the "Capital City Chasers" both performed and instructed the techniques of line dancing.



Dr. Dwalia S. South of Ripley served as Chair, Reference Committee A.



Dr. David G. Hall of Natchez presented the report from the Reference Committee on Consitution and Bylaws.



Dr. Candace E. Keller, of Hattiesburg served as Chair, Reference Committee B.



Dr. Nelson shows off the newest addition to his turtle collection, present by Dr. Mitchell on behalf of the Association.



MSMA Members and guests had the opportunity to participate in the AMA-ERF silent auction held during the Saturday evening MSMA Membership Party given in honor of Dean Nelson.



Members of the MSMA House of Delegates mark their ballots during the House Session on Sunday Morning, May 15.

# **MSMA Alliance 71th Annual Session**



Attending the Alliance Past Presidents' Breakfast were, from left: Kathy Carmichael of Hattiesburg, Peggy Crawford, of Louisville, Karen Stephens, of Hattiesburg incoming MSMA Alliance President, and Mildred Taylor, Southern Medical Association Auxiliary President.

#### 1994-95 Alliance Officers

**PRESIDENT** 

Karen Stephens (David), Hattiesburg President-elect

Jeanne Morrison (William), Hattiesburg
First Vice-President — Membership
Mary Sue Mitchell (Don), Jackson
Second Vice-President — Health Promotions
Rose Lee Robinson (Joe), Jackson
Third Vice-President — AMA-ERF
Melanie Moore (Hal), Pascagoula
Fourth Vice-President — Legislation
Pam Tucker (Shane), Tupelo
Recording Secretary

Barbara Webb (Henry), Jackson Treasurer

Jane Ladner (George), Jackson Parliamentarian

Merrell Rogers (Lee), Tupelo Immediate Past President

Peggy Crawford (Dewitt), Louisville

Alliance members had the special opportunity to tour the UMC Children's Hospital on Thursday afternoon followed by a Reception hosted by UMC medical students spouses. Pictured during the tour were, from left: Dr. Blair Batson, the first Chairman of the UMC Department of Pediatrics, Alliance President Peggy Crawford, Medical School Dean Dr. Norman C. Nelson and Dr. Owen B. Evans, Current Chairman and Professor of Pediatrics at UMC and Director of the Childrens' Cancer Clinic.





The Alliance House of Delegates meeting was held at the Country Club of Jackson, Friday, May 13.



President-Elect of the AMA Alliance Mrs. Barbara Tippins, left, was a special guest during the MSMA Alliance Annual meeting. She is pictured with Mrs. Crawford, right, during the UMC Children's Hospital Tour.

# Thanks to Our 126th Annual Session Technical Exhibitors

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### Dr. Keller Joins MFMC Staff

Candace E. Keller, MD, MHP, has joined the staff of the Mississippi Foundation for Medical Care (MFMC), peer review organization for the state, as consulting clinical coordinator. Duties include coordinating study projects designed to improve the quality of care for Medicare patients.

An anesthesiologist in Hattiesburg, Dr. Keller has the master of public health degree from the Harvard School of Public Health and the MD degree from the Uni-

versity of Mississippi School of Medicine. She received the BS degree in medical technology from the University of New Orleans.

Specialty training came from the University of Texas Medical Branch where she completed her anesthesiology residency and at UMC, her internship and general surgery residency.

Active in both the American and the Mississippi Medical Associations, Dr. Keller serves as alternate director in the state for the American Society of Anesthesiologists, alternate delegate to the AMA and president elect for the Mississippi Society of Anesthesiologists.

In announcing Dr. Keller's appointment, MFMC Medical Director Dr. James S. McIlwain said, "Dr. Keller joins Principal Clinical Coordinator Dr. Alton Cobb in coordinating the Health Care Quality Improvement Program (HCQIP) as we begin working with physicians and providers to improve care provided to Medicare beneficiaries. We feel fortunate to have her on board."

# MFMC Elects Board Members

Ten physicians have been elected to serve through 1996 on the Mississippi Foundation for Medical Care board of directors. The peer review organization's membership consists of Mississippi physicians who each year elect ten physicians to serve two-year terms on the board. The newly elected board members include the following physicians: George Abraham of Vicksburg, Jack Causey Centreville, Hugh Gamble of Greenville, Barney Guyton of Tupelo, David Hall of Natchez, Karl Hatten of Clarksdale, Thomas Holden of Grenada, John Paul Lee of Forest, Glenn Peters of Louisville and Hardy Woodbridge of Jackson. Physicians whose terms expire in 1995 are Tim Alford of Kosciusko, W. R. Arnett of Hattiesburg, Jack Evans of Laurel, Carolyn Gerald of Brooklyn, William Henderson of Oxford, John Cook, Francis Morrison, and Samuel Peeples of Jackson and Jimmy Miller and Max Taylor of Tupelo, 🗅

# **Singing River Medical Society Presents Achievement Awards**

The Singing River Medical Society (composed of 92 Jackson County physicians) established the Singing River Medical Society Award of Achievement in 1991 to recognize and reward excellence in language/communication skills based on English ACT scores as demonstrated by a graduating senior at each of the 7 high schools in Jackson County. Since that date, \$4200 has been awarded. The 1994 Recipients are as follows:

Sandra Nicole Falks - Ocean Springs High School - daughter of Walter and Linda Falks - English ACT of 36 - plans to attend the University of Texan or Loyola.

**Jared Lee Williams** - Pascagoula High School - son of Jerry and Alice Williams - English ACT of 36.

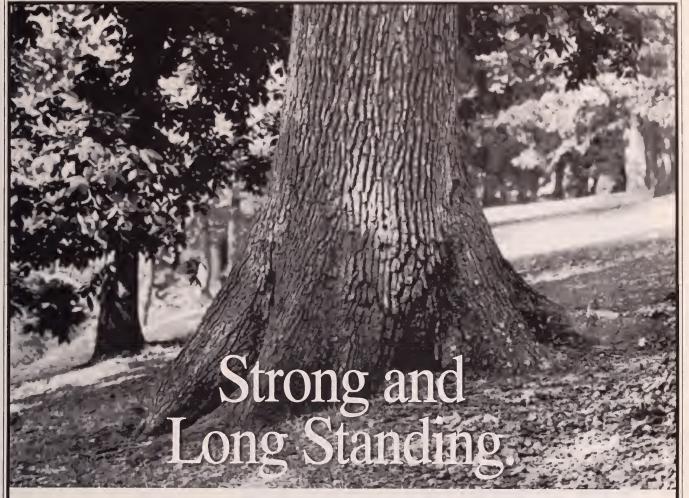
Brandy McDonald - East Central High School - daughter of Mickey and Donna McDonald - English ACT of 32 - plans to attend the University of Mobile. Emily McNally - Resurrection Catholic School - daughter of Chris and Mary

Ann McNally - English ACT of 31.

**Tony Howe -** St. Martin High School - son of David and Beverly Howe - English ACT of 30 - plans to attend Mississippi State University.

Angela Tillman - Vancleave High School - daughter of Irby and Louise Tillman
 English ACT of 30 - plans to attend the University of South Alabama or William Carey College.

Shauna Watts - Moss Point High School - daughter of Mr. & Mrs. Pertis Wattts - English ACT of 29. □



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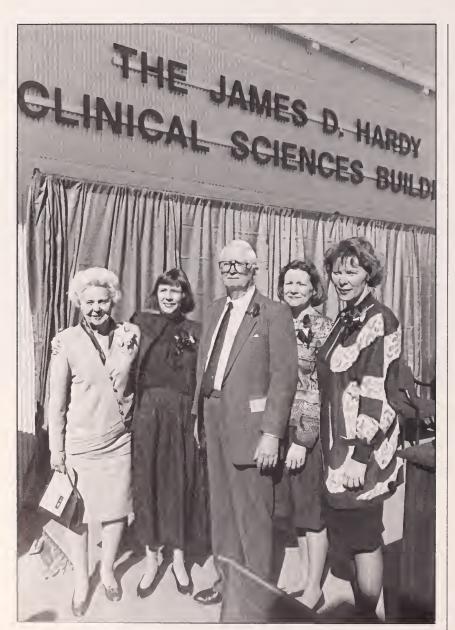
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# The University of Mississippi Medical Center



Hardy Dedication — Three of the daughters of Dr. and Mrs. James D. Hardy attended the dedication of the James D. Hardy Clinical Sciences Building and unveiled the new building name. From left, are Mrs. Hardy, Bettie Winn Hardy, PhD, clinical assistant professor of psychiatry and director of the Eating Disorders Program at the University of Texas, Southwestern Medical School in Dallas; Dr. Hardy, Katherine H. Little, MD, medical director of the Diagnostic Center for Digestive Diseases at Baylor University Medical Center, Dallas; and Louise Roeska-Hardy, PhD, Lecturer in Philosophy at the University of Heidelberg and the University of Frankfurt.

# UMC Clinical Sciences Building Named for Dr. Hardy

The University of Mississippi Medical Center paid tribute to one of its founding fathers during a Feb. 25 ceremony naming the clinical sciences building for Dr. James D. Hardy.

Dr. Hardy was one of the first clinical chairs recruited for the Medical Center by School of Medicine Dean Dr. David Pankratz. He was chairman of surgery from 1955 until his retirement in 1987 and earned world-wide acclaim for his pioneering work in transplant surgery, his many scholarly contributions and his leadership in national and international surgical organizations.

The clinical sciences building, opened in 1977, houses the clinical departments of surgery, ob-gyn, family medicine, neurology, medicine and psychiatry and human behavior.

Dr. Watts Webb, professor of clinical surgery at Louisiana State University and member of the original UMC surgery faculty, said,"... it is most fitting" that this building "be dedicated to memorialize one so instrumental in developing clinical science and practice..."

Dr. Webb, who worked with Dr. Hardy on many of the history making operations performed at UMC, recalled that when University Hospital opened in July, 1955, he made the first rounds with Dr. Hardy "stepping over piles of lumber and brick in the almost completed hos-

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pital."

"Dr. Hardy was a leader, not only of surgery, but a real tower of strength in the development of the school overall." He supported the entire team, Dr. Webb said, but his definition of team included the entire Medical Center and the community.

He showed great foresight, Dr. Webb said, in insisting on allowing full-time faculty to have a private practice and in establishing standards for operating room privileges.

"Most medical schools at that time were staffed by part-time physicians and the intrusion of the full-time professor into private practice was not well accepted. In fact, the University had to sort of elbow its way into private practice. Dr. Hardy early realized that without private practice there could not possibly be enough patients, prestige or money...." to keep the Medical Center afloat.

Dr. Hardy, known the world over for performing the world's first human lung transplant in 1963 and the world's first heart transplant in man in 1964, also did the first parathyroid autotransplant in the United States. "These transplantations are now commonplace, but his bold steps were needed to break the old pattern and allow new worlds to emerge," Dr. Webb said.

"His influence has been multiplied a thousand fold by his publications and even more by the two generations of students and residents who have carried his message throughout the state and even worldwide, as a tribute to the vast impact one man can have."

In response to Dr. Webb's tribute, Dr. Hardy said he was pleased that Dr. Webb had mentioned his impact on surgery in the state. "I have no modesty about it. This department has revolutionized surgery in Mississippi. We've trained approximately 400 surgical special-

ists, of one type or another.

It is now possible to obtain first class surgery, over good roads, in every part of the state."

Dr. Hardy recalled that even though Dr. Pankratz had offered him the position as chairman in 1953, by 1954 he had still not signed a contract. He was getting nervous, he said, because he feared those who opposed him on the issues of faculty practice and board certification for clinical faculty would hold sway.

He was working in Memphis at the time, heading up surgical research at the University of Tennessee. "I was becoming reluctant to move my young family from Memphis where my efforts were increasingly acknowledged and rewarded."

And, he remembered, "things were pretty dicey down there." Chancellor J. D. Williams and Dr. Hardy "met in the lobby of the Peabody Hotel in overstuffed chairs right beside the duck pond. There were five ducks swimming on the

pond. He asked me to tell him how I saw the situation down in Jackson."

Dr. Hardy used most of an hour to explain his ideas about guidelines for faculty practice and who would have operating privileges should be clear-cut from the beginning.

Chancellor Williams left the Peabody convinced that Dean Pankratz had made the right selection, and that the young surgeon's notions should be heeded.

"So many people in this audience have contributed richly to our efforts in surgery," Dr. Hardy said, "staff, residents, nurses, a splendid secretarial force, certainly the laboratory complement and countless others. The James D. Hardy inscription on this building might well consist of a mosaic bearing the names of the host of colleagues who have served the University Medical Center so well. I salute each and every one. It has been an honor to serve the University with them."



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# Dr. Shumway Speaks At Convocation

The major obstacle in heart transplantation is enough donor hearts to fill the need, according to heart transplant pioneer Dr. Norman E. Shumway.

Dr. Shumway, Field Professor of Cardiothoracic Surgery at Stanford University, was speaker for a convocation marking the 150th anniversary of the legislative authorization of the University of Mississippi.

During the Feb. 25 event in City Auditorium, Dr. Shumway gave a brief history of heart transplantation and the current status of the procedure.

In the 1970s, Stanford "was pretty much alone" in doing heart transplants, he said. The center has done nearly 800 of the operations since 1967.

"As late as 1980, Massachusetts General Hospital in Boston was saying that heart transplantation was not essential to its clinical care programs," he said. "Now there are 160 centers performing heart transplants. There are so many programs that some kind of equalization of donors will be necessary."

New immunosuppressive drugs such as Cyclosporine have increased survival rates and made pediatric transplants much more successful. "The newer drugs allow the physician to avoid giving steroids to pediatric patients during their growth and development."

At Stanford, from 1968-1973, only 20 percent of the patients lived as long as one year. Now the five-year survival rate is close to 70 percent, Dr. Shumway said.

Cyclosporine, introduced in the early 1980s, "allowed us to reduce hospital stays, rejection episodes and the number of infections."

Dr. Shumway "developed a



Shumway at Convocation — Dr. Norman Shumway, center, spoke at the academic convocation which was the first events in a series to celebrate the 150th anniversary of the legislative authorization of the University of Mississippi. The convocation celebrated the Medical Center's contributions to the health sciences. Dr. Shumway is flanked by Ole Miss Chancellor R. Gerald Turner, left, and Dr. Norman C. Nelson, UMC vice chancellor.  $\square$ 

laboratory that has contributed more to heart transplantation than any lab in the world," according to UMC's Department of Medicine chairman Dr. John O'Connell who introduced Dr. Shumway.

His 1960 paper, "Orthoptic Transplantation of the Canine Heart," established the surgical technique still used today.

He also defined recipient and donor characteristics, developed the biopsy method of diagnosing rejection, and designed the techniques to procure hearts at a distance alleviating the need to transport the donor to the transplant site, Dr. O'Connell said.

In 1994, Dr. Shumway's lab, which was the first to introduce Cyclosporine, is working with three new anti-rejection compounds each more powerful and much less toxic than Cyclosporine.

"When we began our work in 1958, we started with a list of prob-

lems we knew we had to overcome to make heart transplantation a true clinical option," Dr. Shumway said. Nearly all of them have been solved—surgical technique, organ preservation, rejection. But the factor which still puts limits on heart transplantation is the availability of donor organs, he said.  $\square$ 

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UMC Family Medicine Anniversary — The University of Mississippi Medical Center Department of Family Medicine celebrated its 20-year anniversary at the Ramada Plaza in Jackson. Dr. Wilfred Gillis, left, became the first chairman of the UMC Department of Family Medicine in 1973. Dr. D. Melessa Phillips, right, succeeded Dr. Gillis in 1987 and is the current chairman.

The formation of the department reflected a national concern about the declining number of primary care physicians. The UMC School of Medicine holds the distinction of being the top ranked public medical school in the country in the percentage of its students who choose a family medicine residency.



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# **Personals**

Paul M. Allen a gynecologist and obstetrician practicing in Pascagoula, gave a presentation entitled Risk Management Issues in the Physicians Office: Office Risk Management Activities in a Private Gynecologic Practice at the 1994 Perspective in Medical Management Conference in Washington, DC on May 7, 1994.

Patricia Duggar Allred announce the opening of her practice of Addiction Medicine specializing in the treatment of chemical dependency, 1991 Lakeland Drive, Suite, E, Jackson.

William Lelon Aron of Greenville has successfully fulfilled the requirements of the American Board of Emergency Medicine (ABEM) and is now a Diplomate of the ABEM.

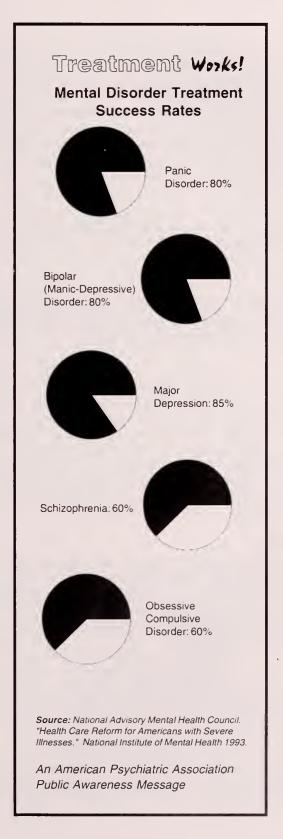
Bryan Barksdale, a cardiologist with Cardiovascular Associates PA, has been named medical staff president at Mississippi Baptist Medical Center, Jackson.

J. David Bullock announces the opening of the Sumrall Medical Center at 1238 Highway 42 in Sumrall.

Rickey L. Chance of Laurel has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFP).

**Guy T. Gillespie, Jr.** of Jackson announces his retirement effective July 1, 1994, from Jackson Oncology Associates, 1190 N. State Street, #501, Jackson.

J. Brooks Griffin of Jackson has been named Chief of Staff at River Oaks Hospital. Dr. Griffin joined River Oaks Hospital's medical staff in 1982 when he began his practice in obstetrics and gynecology.



James R. Hubbard, Jr. of Tupelo recently qualified as a certified Medical Review Officer. He was certified by Medical Review Officer Certification Council, an independent organization that conducts an extensive application process and examination to identify physicians with the highest professional standards of medical expertise and practical skills necessary to evaluate drug and alcohol test in public and private sectors of the workplace.

Baxter P. Irby, Jr, and Ray Montalvo, Jr., announce the relocation of their offices to 513 Brookman Drive, Brookhaven, MS.

**Thomas P. Milis**, a gastroenterologist in Jackson, recently attended an advanced therapeutic ERCP course at Duke University Medical Center.

Frank J. Morgan, Jr., of Jackson was recently appointed to an additional three-year term on the FSMB Examination Board by the incoming President, Gerald J. Bechamps, of Winchester, VA at the annual meeting of the Federation of State Medical Boards held in Washington, DC. Dr. Morgan was part of the meeting program in discussing the Examination Board's plans for enhancing the SPEX (Special Purpose Examination).

Francis Morrison of Jackson, recently attended the meeting of the Fourth Argentine Congress of Transfusion Medicine in Cordoba, Argentina, where he served as a member of the International Scientific Program Committee and presented three lectures on Transfusion Medicine.

Nannie Pidlklti announces the opening of her new office in Suite 104, Magnolia Doctor's Plaza, Alcorn Drive, Corinth.

Louis V. Pumeky, will associate with Jackson Oncology Associates, 1190 N. State Street, Suite #501, Jackson on July 1, 1994.

Walter R. Shelton of Jackson presented a paper at the American Academy of Orthopaedic Surgeons Meeting in February in New Orleans on Bracing of Anterior Cruciate Ligament Tears in Athletes and taught a course in Arthroscopic Implantation of Meniscal Allografts in San Diego, California in April.

Clark G. Warden of Pascagoula recently received Certification of Added Qualifications in Surgical Critical Care by the American Board of Surgery.

Victor W. Yawn a family physician in Jackson has been named medical director of Methodist Home Care Services, Jackson. □



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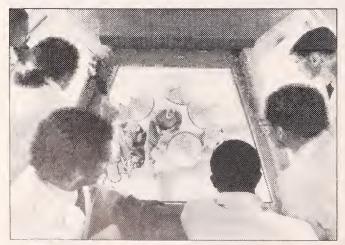
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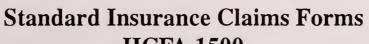
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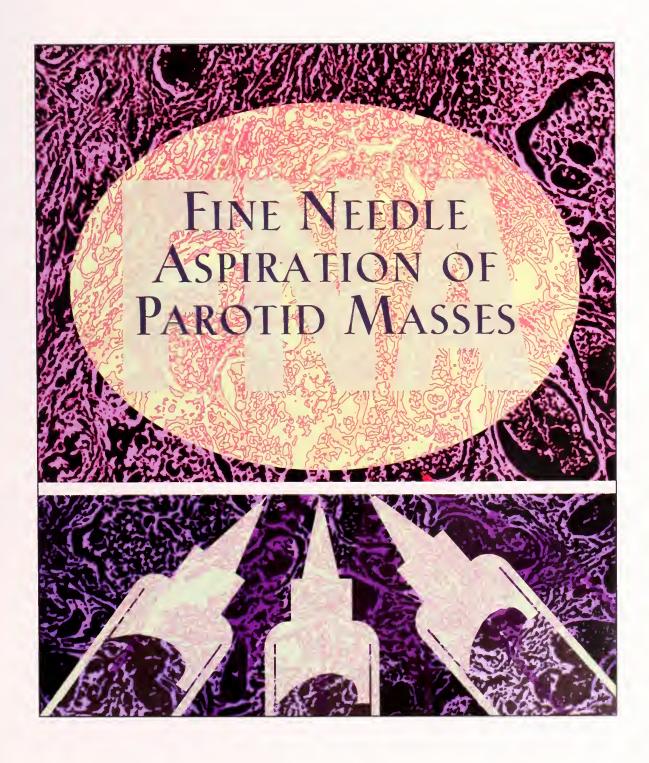
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**VOLUME XXXV** 

NUMBER 7

## **SCIENTIFIC ARTICLES**

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# Find Needle Aspiration (FNA) of Parotid Masses

C. Ron Cannon, MD, FACS

Parotid masses often present a diagnostic dilemma for the clinician. Despite the anatomic location and relatively high profile of the parotid gland, these masses can be quite large by the time medical attention is sought. Parotid masses may be broadly considered to be inflammatory or neoplastic. If neoplasm is considered, surgery with its potential for risk to the facial nerve is indicated.

In the mid-1960's, fine needle aspiration (FNA) became popular in the Scandinavian countries and subsequently in this country. In essence the material obtained by FNA is spread onto a glass slide. The specimen is then air dried or sprayed with a fixative. The material is then stained and reviewed microscopically to arrive at a tissue diagnosis (Figure 1).

FNA has a variety of uses in the diagnosis of head and neck lesions. Its greatest use is perhaps in the diagnosis of metastatic squamous cell carcinoma.<sup>1</sup> FNA has also been used in the diagnosis of

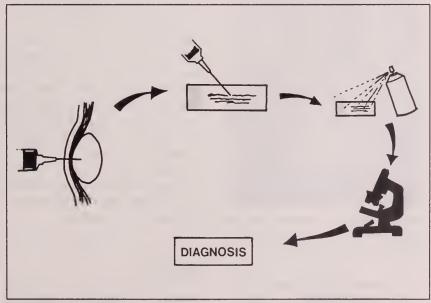


Figure 1. Schema utilizing the technique of FNA.

thyroid nodules.<sup>2,3,4</sup> FNA may be used in the diagnosis and occasionally drainage of benign lesions such as peritonsillar abscess.<sup>5</sup>

The purpose of this article is to review the author's experience with fine needle aspiration of various parotid lesions encountered in a clinical setting. Of specific interest are its sensitivity and specificity in the diagnosis of tumors, and the reliability of the tissue obtained by FNA. Another purpose is to introduce this technique to those who may not be familiar with it.

#### **TECHNIQUE**

FNA can be carried out in an office setting and does not require any anesthesia. The mass is immobilized between the thumb and forefinger. An alcohol prep sponge is used to cleanse the skin overlying the mass.

I use a specially designed syringe pistol which can accommodate a 10 cc syringe (Figure 2). A 3 cc or 5 cc syringe can also be used. A 21 or 22 gauge needle is used for biopsy purposes. Although larger needles have been used, it should be noted that with a large bore needle there does exist the possibility of tumor seeding along the needle tract.



Figure 2. Syringe pistol used for fine needle aspiration of masses in the head and neck.

The mass is punctured with the needle without suction on the syringe. Once the operator is certain that the needle is within the mass, suction is applied to the syringe pistol to provide a vacuum. The needle is moved to and fro within the mass to provide adequate sampling of the mass (Figure 3). When material is seen to enter the hub of the needle enough material has been obtained for diagnostic

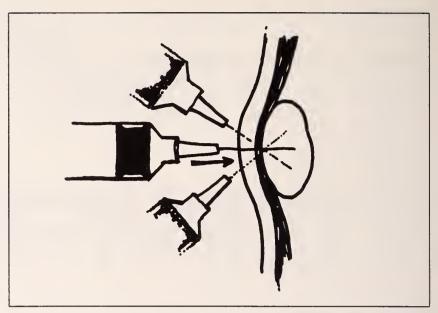


Figure 3. The needle is moved to and fro within the mass. Multiple passes of the needle within the mass decreases the chances of a sampling error.

purposes and the aspiration is terminated. Before removing the needle from the mass the vacuum on the needle is released.

The needle is detached from the syringe. Air is drawn into the syringe. The needle is then reattached and the contents from the needle expelled onto a glass slide. The slides may be air dried or immersed in 95% ethyl alcohol and then stained with Papanicolaou or Romanovsky's stain.

Light pressure is applied to the puncture sight for a few minutes and a bandaid applied. Analgesics are usually not required.

#### **METHOD**

The study group consisted of twenty-five patients in whom a FNA of the parotid gland with subsequent surgery for definitive histologic diagnosis were studied in a retrospective fashion. It should be noted that many patients not in this study group underwent FNA with the diagnosis suggesting an inflammatory lesion, were treated medically, and did not require surgery.

Within the study group there were eight males and seventeen females. The average age for the males was 53 years, 51 years for females. The average age for the entire study group was 52 years (Table I). There were twenty-two patients with a FNA diagnosis of salivary tumor, twenty of this number were subsequently found to have a neoplastic growth. Of the various salivary tumors, there were fourteen benign tumors and six malignant. The most frequent tumor diagnosis was benign pleomorphic adenoma (Figure 4). The various tumor types diagnosed by FNA

# TABLE I

n = 25					
Males 8 Females 17	Average age Average age	53 51			
Pathology:					

Salivary neoplasm 20 Lymphoma 1 Sialadenitis 3 Intra-parotid node 1

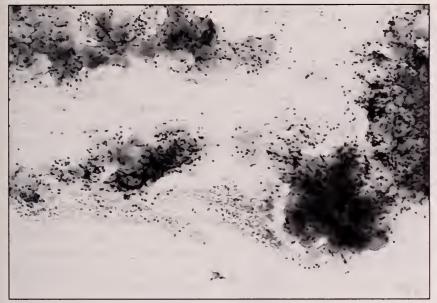


Figure 4. Benign pleomorphic adenoma as seen in fine needle aspiration. This photomicrograph reveals nests of acinar glandular elements with scant stromal tissue lacking cellular atypia.

# TABLE II Neoplasms of parotid gland diagnosed by FNA

D	T	ATI		'N
ж	м	rv.	16.	-

Pleomorphic adenoma 12 Warthin's tumor 2

#### **MALIGNANT**

Adenocarcinoma	1
Mucoepidermoid Carcinoma	1
Squamous Cell Carcinoma	2*
Malignant Mixed Tumor	1*
Acinic Cell Carcinoma	] **
Lymphoma	1***

- One of the lesions in the squamous cell carcinoma group and the malignant mixed tumor were malignant on FNA but the exact histologic diagnosis could not be determined.
- \*\* Thought to be a benign neoplasm on FNA
- \*\*\* Atypical lymphocytes on FNA led to an open biopsy and subsequently a diagnosis of lymphoma.

are listed in Table II. There was one patient who had a diagnosis of sialadenitis subsequently verified by surgery.

There were no complications related to FNA such as pain (requiring more than plain Tylenol for control), hematoma or facial nerve palsy. There were no cases in which the tissue obtained was insufficient for review or non-diagnostic. At surgery, there were no cases in which there was evidence of tumor spillage due to FNA along the tract of the needle.

#### COMMENT

The main value of fine needle aspiration in the setting of parotid disease is its reliability in the diagnosis of salivary gland neoplasms. In this sense the sensitivity or positive diagnosis in the presence of a neoplasm was 92%. There were two patients in this series in whom fine needle aspirate suggested the possibility of neoplasm. On histologic study, however, only chronic sialadenitis was seen. The proliferation of intercalated ducts replacing most of the salivary tissue within chronically inflamed glands might account for this false positive diagnosis. There was one patient in this series with a benign inflammatory sialadenitis which was found on histologic examination and correctly identified before surgery with a fine needle aspiration. Fine needle aspiration was very reliable in the diagnosis of benign parotid neoplasms. In this series, a correct diagnosis of pleomorphic adenoma in twelve patients and a Warthin's tumor in two patients was made. The sensitivity of 92% in this series compares favorably with other series of patients having undergone fine needle aspiration.6,7 In these two series of patients from the same academic center the sensitivity was 92-93%.

There were seven patients in this series who had malignancies within the parotid gland. One was a lymphoma, suspicion of which was correctly identified on fine needle aspiration. Of the remaining six patients, five were identified on fine needle aspiration as having a malignant process present. Fine needle aspiration correctly identified an adenocarcinoma within the parotid gland in one patient, a mucoepidermoid carcinoma in one patient, and a squamous cell carcinoma in one patient (Figures 5 & 6). In two other patients, a malignant process was suspected with the fine needle aspiration showing a poorly differentiated carcinoma. In one patient, a malignant mixed tumor was seen and in the other, a poorly differ-



Figure 5. Adenocarcinoma of the parotid gland correctly identified as adenocarcinoma or FNA. The individual cells show nuclear enlargement and hyperchromatism. Nests of tumor cells are noted.

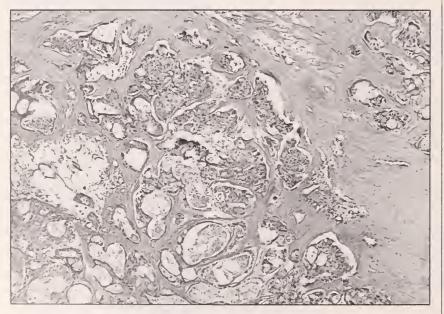


Figure 6. Histologic Section of adenocarcinoma seen in FNA in Figure 5. (H & E, 90X). The tumor is a moderately differentiated adenocarcinoma with glandular characteristics.

entiated squamous cell carcinoma was found. Thus if a malignant process was present, fine needle aspiration in this series correctly identified the lesion 86% of the time. This compares very favorably with other series in which the diagnostic accuracy for malignant tumors was from 50-86%.

The specificity or negative aspiration in the presence of tumor with fine needle aspiration in this series was 96%. In one patient, a benign parotid neoplasm was suspected and the patient found to have on extensive histologic review a malignant acinic cell carcinoma. The specificity or false negative

rate compares favorably with a series by Frable and Frable, as well as a series by Abad et al.<sup>6,10</sup> In fact, one could argue that the false negative rate in this series, realistically, is 0%. The patient was diagnosed as having a parotid tumor and was to undergo surgery based on this finding. There was no delay in the patient's treatment caused by the false negative fine needle aspiration.

The cost of fine needle aspiration is important in the overall management of the patients. The cost of fine needle aspiration is roughly \$50 in an office setting. An additional cost of \$50 to \$100 is common for processing charges thus the overall cost of fine needle aspiration is in the range of \$50 to \$150. In a March 1991 article by Frable and Frable, they estimated hospital charges of \$8,700 for a parotidectomy.6 The value of fine needle aspiration of the parotid gland lies in being able to accurately select out those patients who have a tumor and need surgery versus those with inflammatory or other problems which can be managed medically in a less expensive manner.

A final important consideration is that of avoidance of unnecessary surgery. Complications associated with parotidectomy include seventh nerve palsy, postoperative abscess, or hematoma which might require reoperation or a prolonged hospital stay. In one series, there was a patient who died of a stroke on the second postoperative day following parotidectomy and was subsequently found to have no neoplasm on hislogic review.

#### CONCLUSIONS

Fine needle aspiration plays a significant role in the management of parotid masses. The patient can be advised in an expeditious fashion if they have a problem which can be treated medically or informed that surgical treatment is necessary. Many patients may be spared consideration of surgery altogether. It must be remembered, however, that the cytologic findings from fine needle aspiration must be correlated with the patient's clinical picture when formulating a treatment plan.

The sensitivity of FNA in diagnosing parotid masses correctly in th.s series was 92%, it specificity 96%. FNA is recommended as a crucial initial step in the management of patients who present with parotid masses.

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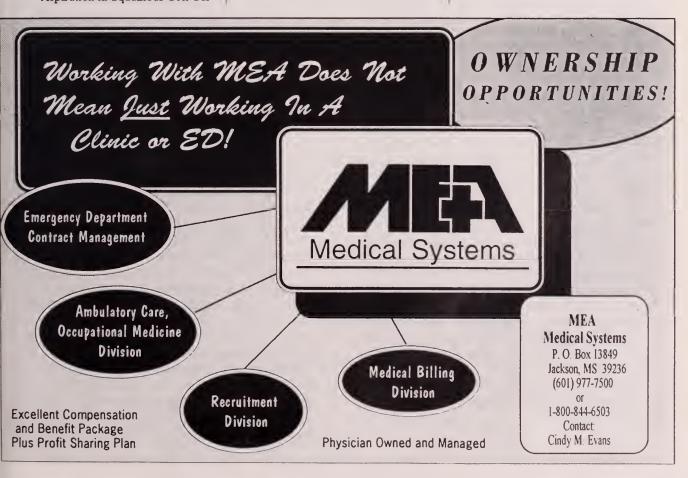
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Dr. Cannon is in the private practice of Otolaryngology, Head and Neck Surgery, at the Head and Neck Surgical Group, Jackson, MS.



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# CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

### Clinicopathologic Conference VI

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Differential Diagnosis: Radiological Findings: Pathological Findings: Bernard J. Dreiling, MD Gregory N. Vickers, MD E. Rhyne Flowers, MD

#### **CASE PRESENTATION**

An 82 year old black female presented to the University Medical Center Emergency Room after falling and injuring her left shoulder. Although this was her chief complaint, she also complained of increased swelling involving her entire body with worsening shortness of breath and orthopnea (sleeps sitting up). Other than mild diffuse abdominal discomfort, she voiced no other complaints. She stated that she had been out of her fluid pill for one month prior to admission. However, on examination of her medications, she was noted to have a full bottle of Lasix.

Her past medical history was significant for hypertension of unknown duration, congestive heart failure of uncertain etiology for which she was previously hospitalized five months earlier. At that time she was diuresed with Lasix and started on Captopril. An echocardiogram obtained at that time was significant for global LVH, moderate MR, and with an EF of 57%. She also has a history of iron deficiency anemia felt to be due to recurrent epistaxis on prior workup. Her operative history is remarkable only for hysterectomy in distant past.

She supposedly was taking Lasix 40mg po BID,

Captopril 37.5mg po TID, Iron Sulfate 325mg po TID, and Folate 1mg po qd. She had no known allergies and no history of smoking or alcohol abuse.

On examination, her temperature was 98.0, her pulse was 72, her blood pressure was 100/45, her respiratory rate was 28, and there was no paradox. She was an elderly very ill appearing black female. Her HEENT was remarkable for significant periorbital edema bilaterally, somewhat worse on the right. Otherwise, she only had bitemporal wasting and bilateral cataracts. Her neck was supple. She had JVD to at least the angle of the mandible when sitting at 90°. It actually extended up onto her forehead. She did not have a detectable Kussmaul's sign. She did have a soft bruit over her left carotid.

Her cardiovascular exam revealed a heart with a regular rhythm with occasional PVC's. She had a grade 2/6 holosystolic murmur at the base, but no S<sub>3</sub> or S<sub>4</sub>. She had bibasilar rales up to the level of the scapula. She had some mild diffuse tenderness with no rebound or guarding. The liver was palpated 3cm below the right costal margin. There were normal active bowel sounds. She had significant pitting edema extending up to her sacrum and over her abdomen. She had chronic skin changes with some desquamation of the lower extremities, but no cyanosis or clubbing. No adenopathy was noted. Neurologically, she showed only a left central CN VII palsy with a decreased nasolabial fold on the left.

Laboratory obtained at the time of admission was pertinent for a sodium of 144 with a potassium of 5.1. Her BUN and creatinine were 52 and 1.4. Hemoglobin was 11.8 with a hematocrit of 35, a platelet count of 297,000, an MCV of 89, and RDW of 17.2. Her total protein was 6.8 with an albumin of 2.5, total bili of 2.1 with a direct bili of 1.2, and her GPT was 20, GOT was 62, and GGT was 189. Urinalysis was remarkable only for one red blood cell. RA ABGs at the time of admission were PO2 of 96, PCO2 of 37.9, and a pH of 7.45. Admission chest xray showed an enlarged cardiac silhouette with left atrial enlargement and increased pulmonary vasculature. Her EKG showed normal sinus rhythm with an occasional PVC. Shoulder x-ray obtained at admission was unremarkable.

She was admitted with a working diagnosis of cardiomyopathy of uncertain etiology with an exacerbation of her congestive heart failure due to improper use of her medications. She was started on IV Lasix with the addition of Metolazone with excellent diuresis throughout her hospital course. Her Captopril was discontinued since she was felt to have a restrictive cardiomyopathy with diastolic dysfunction. A repeat ECHO revealed concentric left ven-

tricular thickening but normal LV size, an enlarged right ventricle, right atrium, and left atrium and moderate to severe mitral and tricuspid regurgitation.

A gaited heart scan was unable to be performed due to the irregularity in the patient's heart rate. Also obtained during the admission was serum protein and urine protein electrophoresis, both of which were unremarkable.

The next tests that were ordered suggested the diagnosis which was confirmed by a procedure. What are the tests? What is the diagnosis?

Dr. Dreiling: I think we all agree that the presenting event in this patient is, without question, edema. The edema was bilateral. We can assume it was progressive as it didn't occur in a day or two. It had been going on for several months prior to admission. The key physical finding, in addition to edema, suggesting right sided heart failure was the marked distention of her neck veins. If at this point in time I had no knowledge of her prior ECHO, which we are given as part of her past history, I would wonder next if there is evidence of left sided failure. Evidence for left sided failure would rule out rare things like carcinoid, a right atrial myxoma, tricuspid stenosis, and the like. We do in fact have evidence of left sided failure. Even though she has no S3 and we are not told about her cardiac apex impulse, she does have rales up to her scapula and probably higher. Her chest x-ray shows evidence of left sided heart failure, namely, cardiomegaly and prominent vascularity with cephalization. This would cause me to favor bisided heart failure. Recall that we are taught from the very first days of medical school that in most patients who present with right sided failure the heart failure is usually caused by, or at least associated with, failure of the left side of the heart.

What are the usual causes of bisided heart failure? We're told she has a past history of hypertension, though I doubt that. Her fundi are benign, I assume, as nothing was mentioned about hypertensive retinal changes. Her blood pressure was 100/45, hardly elevated, although she was supposed to be on an ACE inhibitor. Her renal function, although not normal, is not that bad with a creatinine of 1.4. Her electrocardiogram showed no LVH. I think hypertensive heart disease is unlikely. In most instances, the most difficult diagnosis to exclude even in an 80 year old patient would be coronary heart disease. This patient has no history of angina. She gave no history of an acute myocardial infarct in the past. Her electrocardiogram, although it showed poor R wave progression across the precordium, did not show other evidence of a recent or a remote myocardial infarct.

Finally, one can occasionally in elderly patients see calcification of the coronaries which she did not have on chest x-ray. Rheumatic heart disease in an 82 year old patient, given the finding of a holosystolic murmur of either mitral or tricuspid regurgitation, would be most unlikely so I will discount that. Pericardial effusion may be evident as mild cardiomegaly on chest x-ray and there will be distended neck veins, but generally the lung fields are clear, there are no rales, and the chest x-ray shows no evidence of pulmonary congestion. In our patient it did. Furthermore, we are told there is no paradox and there is no Kussmaul or inspiratory distention of the neck veins. Hence, I think pericardial effusion is unlikely.

I am left then with two major diagnostic considerations: does this patient have a cardiomyopathy, or does she have constrictive pericarditis. The most common cardiomyopathy that we see at the VA and probably at UMC is a dilated cardiomyopathy, usually idiopathic. She does have low voltage; that certainly fits any cardiomyopathy but I think a dilated cardiomyopathy in this lady is unlikely for several reasons. First of all, she gives very little evidence of left ventricular systolic hypofunction; in fact we know from her echo that her ejection fraction a few months previously was 57%; not bad for an 82 year old lady. She gave no signs or symptoms suggestive of poor left ventricular output. Her ECHO showed a normal size left ventricular cavity which is very important in someone who has an enlarged heart. Finally, patients with dilated cardiomyopathies will sometimes give histories suggesting one or more systemic emboli. Such was not the case. An EKG interpretation was not given in the protocol so we didn't know about the patient's low voltage.

Given this patient's age of 82, most of us would put hypertrophic cardiomyopathy rather far down on the list as over two thirds of the patients are under 60 years and most of them are even younger than that. However, here again she gave no aortic stenosis type symptoins suggesting a narrow pulse pressure and poor cardiac output. She didn't have the typical crescendo decrescendo diamond type murmur, but rather had a holosystolic murmur. She had no LVH on EKG, which you should see with a hypertrophic cardiomyopathy. These patients usually have little evidence of heart failure on x-ray. Finally, her ECHO makes no mention of the fact that she has asymmetric septal hypertrophy and systolic anterior motion of the mitral valve. We are left then with a diagnosis of constrictive pericarditis or restrictive cardiomyopathy.

Before discussing either of these in further detail, I should make mention of the fact that sometimes you can't distinguish one from the other until you

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get the result of a biopsy of the right heart. Even then, if the biopsy is inconclusive, you may still wonder which of the two is the problem. In most cases, both clinically and with routine studies, you can differentiate constrictive pericarditis from restrictive cardiomyopathy. In constrictive pericarditis the whole clinical picture is primarily dominated by evidence of failure of the right side of the heart with little or no evidence of failure of the left side of the heart. There often is a Kussmaul sign, which we mentioned earlier is inspiratory distention of the neck veins. If you look at the jugular venous pulse, you appreciate a very rapid, wide dissent in a patient with classic constrictive pericarditis. We're told she doesn't have a Kussmaul sign. There is no mention of her venous pulsations. These patients typically have ascites. Whether she has ascites or not, I can not say. She has tenderness on examination of her abdomen and her liver is enlarged but we are not told if she had hepatojugular reflux. If she had a small amount of ascites, it wasn't obvious. In patients who have constrictive pericarditis, you usually do not feel the apex beat. Since it was not mentioned, we can not say. If you listen early in diastole, about the time one hears an opening snap, you may hear a diastolic knock in patients who have constrictive pericarditis. She did not have this. These patients will usually have remarkably clear lung fields. Over half of them will show calcification of the pericardium on the plain film of the chest which she didn't have. The ECHO is most helpful. It may show a thickened pericardium, which would favor constrictive pericarditis. The valves are usually not involved as they were in this patient and there is little evidence of either tricuspid or mitrol regurg on physical examination. Cardiac catheterization in constrictive pericarditis shows equalization of right and left ventricular and diastolic pressures. Further more, if you look at the right ventricular pressure tracing, you will see a so-called square root sign with a dip and a plateau in mid diastole. I do not think this patient has constrictive pericarditis.

Like dilated cardiomyopathy, about half the time in restrictive cardiomyopathy we find no obvious cause. We need to give thought to some of the things that may cause restrictive cardiomyopathy and we will quickly run through the list, discounting the first 10 or 11 and then telling you why I favor amyloidosis. Radiation exposure - no history. There is no history that this patient received Adriamycin. Hemochromatosis in an 80 year old woman is very unlikely, in fact in an 80 year old man highly unlikely. Furthermore, when hemochromatosis affects the heart, it is usually a dilated type of cardiomyopathy rather than a restrictive type. Her blood sugar is normal -

hemochromatotics have diabetes. Her liver tests are a bit abnormal, but that is likely because of her failure, possibly because of her amyloid. Finally, this patient is mildly anemic; hemochromatotic patients are not anemic, and, in fact, if you suspect hemochromatosis and find anemia, that diagnosis is highly unlikely. Pseudoxanthoma, we mention only for completeness. She obviously did not have it. Endomyocardial fibrosis is primarily a tropical disease and typically associated with eosinophilia. We do know that this patient had no eosinophilia on differential. Furthermore, those patients are usually young, around the age of 20. Nontropical, so-called, Loffler's syndrome, a pulmonary problem associated again with eosinophilia is again unlikely in an 82 year old woman. Sarcoidosis should be mentioned. Sarcoidosis frequently does involve the heart, but, like hemochromatosis, it typically causes a dilated cardiomyopathy and not a restrictive cardiomyopathy. Furthermore, patients with sarcoid involvement of the heart more often have evidence of pulmonary hypertension and corpulmonale. They often have arrhythmias and heart blocks. Scleroderma among the collagen vascular diseases would be the one to consider, but again scleroderma, like several we've mentioned, usually causes a dilated cardiomyopathy. Furthermore, almost all patients who have cardiac involvement secondary to scleroderina will have evidence of esophageal dysfunction and they will have dermatologic evidence of scleroderma, which she didn't have. At autopsy, in patients who have cancer about 5 - 10% will have involvement of the heart. Similarly, in leukemia and lymphoma, there may be involvement of the heart. However, involvement of the heart in leukemia and lymphoma is typically silent and is not diagnosed ante mortem. Furthermore, in lymphoma and sometimes in leukemia if there is involvement of the heart that is clinically significant, it will often be pericardial, sometimes with effusions. Finally, if you biopsy and make no diagnosis, we tend to label that idiopathic, particularly in younger patients.

In most series, as I can best tell, in those patients with restrictive cardiomyopathy in whom a diagnosis can be made, the most common diagnosis will turn out to be amyloidosis. Frankly, it is not all that rare. We see several a year and we're frequently asking cardiology to take another look at the ECHO because sometimes the ECHO at least strongly suggests amyloid cardiomyopathy. Patients who have amyloid cardiomyopathy may have symptoms and signs very much like the patient who has constrictive pericarditis, and that's why I feel that constrictive pericarditis is one of the things you initially need to strongly consider and rule out. They may have a Kussmaul, they

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may have a rapid wide "y" descent, they may occasionally have a paradox, but the apex beat in restrictive amyloid cardiomyopathy will usually be palpable, unlike constrictive pericarditis. They usually have an S3, which she didn't have, often will also have an S4, and will usually have involvement of both mitral and tricuspid valves. This lady has a holosystolic murmur. We're not told about Carvallo's signs, so clinically we can not tell if it's mitral or tricuspid. Her chest x-ray does show congestive heart failure and does show a moderately enlarged heart. The EKG shows classic low voltage, seen in most types of cardiomyopathy and seen in this patient. There appeared to be no conduction delay; at least I didn't see one and no Q wave was apparent. Amyloid patients frequently will have a Q wave present. The EKG showed poor R wave progression, but I don't think that counts as a pseudoinfarct picture of amyloid heart disease.

Most of the time, if we haven't suspected amyloid clinically from the serum or urine protein findings, we suspect it because of what the ECHO shows. She had symmetric thickening of the left ventricle, and the right ventricle was likewise involved as were the atria. Both AV valves were involved as well as the papillary muscles. She had generalized infiltration of her heart, primarily left ventricular, but other areas of the heart as well. Her systolic pumping function was quite good with ejection fraction of 57%. Scans using technetium are sometimes done in patients who are suspected of having amyloid, but are less helpful than the ECHO because they less often show a characteristic picture. If you do a technetium scan of the heart, classically in patients who have amyloidosis there will be intense uptake of the tracer by the heart. We're not told if this patient had a scan or not. Finally, on cardiac catheterization, unlike in restrictive pericarditis, the left ventricular enddiastolic pressure will typically be higher than the right ventricular unlike the equalization we see in patients who have constrictive pericarditis. Usually the left ventricular will be at least 10mm greater than the right ventricular pressure. Furthermore, if you look at the right ventricular pressure curve, there will be continued rise during mid and late diastole unlike the plateau picture and square root sign we mentioned constrictive pericarditis. This is a technetium scan showing intense uptake of the label by the heart on both AP and lateral views. For those of you who haven't seen intense uptake, it's typical of amyloidosis.

Returning to this patient and looking at some other significant lab: I was asked what further test was or were obtained and what diagnostic procedure was per-

formed. Let me tell you that the further tests that suggested a diagnosis to me would have been different given the data base from this patient than what may, in fact, have been done; it depends on whether you are leaning towards a career in cardiology or whether you're leaning towards a career in hematology. Looking at the rest of her lab, the things that suggest amyloid to me are: her serum total protein, although normal to a bit high; because she is hypoalbuminemic with an albumin of 2.5g/dl her globulins are elevated. We weren't told in the protocol that she had a serum and urine electrophoresis and that they were normal but that still doesn't influence me in my suspicion for amyloidosis. Her globulins are elevated and as we encourage you from third year medical school on, elevated globulins for no obvious reason require at least serum protein electrophoresis to see if the pattern is polyclonal or monoclonal. The fact that her urine doesn't show protein, although we're not told she doesn't have protein (we're told today), doesn't influence me either because most of you have been told since third year that the Bence Jones protein does not react with the usual screen for protein which doesn't use sulfosalicylic acid. The fact that this lady's globulins are high warrants the protein electrophoresis and even though her urine is said to be negative, I would have electrophoresed her urine.

One might think that if we are diagnosing amyloid, this patient must have myeloma. In fact, she probably doesn't have myeloma and the reason I think she doesn't have myeloma is apparent from some other lab. She has very little anemia. Myeloma patients generally don't have 12gms of hemoglobin: in fact, in heart failure the Hgb may be even higher. She has no anion gap suggesting a monoclonal IgG protein. She has no pseudohyponatremia. Her sodium is 142. Although we have just an x-ray of her shoulder since that's why she initially presented, the chest film doesn't report any lytic lesions in the ribs or vertebra. Her renal function, although not normal, is not significantly impaired. We're not told that she has an elevated calcium. What further tests might have been obtained that suggested amyloidosis in this patient? I would have looked initially at both serum and urine electrophoresis. If this patient's ECHO at all suggested a sparkling or scintillating pattern, that would have suggested amyloidosis and made me proceed with a biopsy. If this patient had a technetium scan, mild to moderate uptake on scan would be nonspecific. In fact, as most patients who have cardiac amyloid don't have a classic intense pattern, certainly of the two tests the ECHO would be far the more sensitive test. The diagnostic proce-

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dure would have been an endomyocardial biopsy.

Before turning this over to the people who are going to really tell us what this patient has, let me make one point very clear. Most patients who have amyloidosis of the heart do not have myeloma. They have a plasma cell dyscrasia but they do not have the classic typical features of myeloma. Over 2/3 of the patients with amyloidosis have what's called primary amyloidosis, non-myeloma associated amyloid. Most of the rest will have myeloma associated amyloidosis. So-called secondary amyloid, the most common type in Europe and England, is uncommon in this country. I don't recall when we last saw one; maybe years ago in a bronchiectatic. A second point I'd like to make about amyloidosis is that most patients who have primary amyloidosis do not have elevated globulins. If you do a serum protein electrophoresis on patients who have primary amyloidosis, it may show a polyclonal pattern. The reason for this is that most patients with primary amyloidosis have evaluated monoclonal light chains. Monoclonal light chains, because of their size, are quickly filtered and excreted in the urine. They have little chance to accumulate in the blood stream. So, the electrophoretic pattern may show a nonspecific polyclonal image. But, if you look at the urine, even though it's negative by dip stick, you will frequently find monoclonal light chain present. The bottom line here is that if you suspect amyloidosis of the heart in a patient who doesn't have obvious myeloma, you need to obtain immunoelectrophoresis of both serum and urine to confirm that the patient has a monoclonal light chain. Total proteins may not be elevated. In fact, total globulin may be low. They may have hypogammaglobulinemia. Immunoelectrophoresis should be obtained before doing a biopsy in a patient suspected of having cardiac amyloidosis.

Dr. Vickers: The initial x-ray findings are fairly non-specific. There are marked degenerative changes about the left shoulder. This is actually several days after admission. She still has a large pleural effusion on the left with ectasia of the aorta and some old rib fractures on the left. She still has a degree of increased blood flow and interstitial prominence. This x-ray was obtained the same day as the technetium scan which we will project here. This study was imaged actually three hours after the injection of the technetium phosphate. Technetium phosphate was initially used for a bone imaging agent. Therefore, you'll see fairly decent skeletal uptake. This is a 45 LAO projection, a true anterior projection, a 70 LAO projection, and this is a left lateral projection. We have skeletal uptake, we have left shoulder uptake, and we also have myocardial uptake, or rather radiotracer over the region of the heart. Delayed ejection fraction can cause an apparent increase in tracer uptake over the heart because it's not distributed over the blood stream. It's delayed blood pool activity. So, if you were suspicious of that you'd need a delayed image to insure that it didn't wash out of the region of the heart and it wasn't just blood pool activity. This is suggestive of amyloid but it's also suggestive of myocarditis or cardiomyopathy or any sort of pericarditis with calcification because the skeletal agent will be taken up in calcification. Although it's consistent with amyloid, it's not pathognomonic. This is a fairly intense uptake. It's at least as intense as the sternum, and it's probably greater than the ribs. It would be a grade 3 or grade 4, depending on which classification you wanted to use.

Dr. Flowers: The patient underwent a cardiac catheterization and we received about five ventricular biopsies. Without any clinical history and just looking at this, I might think of just scarring or fibrosis. There are the normal brightly eosinophilic cardiac fibers and then something is replacing the fibers - a kind of whitish pink tissue and it's really fairly extensive. Here's another biopsy and again you can see these changes. As we go to higher power, you can see in the very central region this amorphus eosinophilic material that doesn't look like collagen or fibrous tissue when you look at it on high power. It's actually causing compression atrophy of adjacent fibers and replacing fibers. Of course, when we suspect amyloid we do a congo red stain and this is your typical positive finding in the central area. There's some positivity in the left corner and then scattered about in the interstitium. We polarized it. It's apple green and is positive. Another stain that we like to do is called a sulfated alcian blue stain. Studies have shown that it's a little more sensitive than the congo red. The amyloid is the jade green and we use a counter stain, which stains the cardiac fibers yellow. She also had some really large nuclei that were irregular that you might think of hypertrophy. On the slides shown we can't tell which type of amyloid it is, but there are some monoclonal antibodies that you can use with immunoperoxidase studies if you wanted to differentiate AA from AL amyloid.

Diagnosis: cardiac amyloidosis 🗆

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- Dr. Files is Professor of Medicine and Associate Chairman for Clinical Affairs; Dr. Dreiling is Professor of Medicine; Dr. Vickers is Resident in Radiology; and Dr. Flowers is a Resident in Pathology, all at the University of Mississippi Medical Center.
- Dr. Brown and Dr. Olinde were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1992-1993.

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The President's Page MALLAN G. MORGAN, MD

### The Reformation Of Health Care

n the first place, Health Care Reform, as proposed by President and Mrs. Clinton is a I misnomer. It is more a reformation of health care financing than a change in the provision of health care. You and I think of health care as the treatment of patients and their illnesses. The Clinton's plan and the other plans on Capitol Hill are concerned more with the financing of Health Care and only somewhat with it's delivery. It is the financing of Health Care, if it is accepted as a given that the President will veto anything short of "universal access" as he has promised, that will make or break any of the current plans. Business is against the employer mandate to provide health insurance, and this doesn't cover the retired and unemployed anyway. The individual mandate or the health care IRAs also don't cover the retired or unemployed. If Medicare and Medicaid continue as they are or are expanded to cover the retired and unemployed, and everyone else in the country is covered by one of the other plans, the cost to the American public would be staggering. The money would have to either come through the purchase of "insurance", of whatever kind that provided the basic package agreed to by Congress, or through higher taxes. And for those that didn't buy into one of these packages, there would have to be a financial penalty. All in all, the financing of health care reform as is being proposed, if it is to be "universal", will be a bitter pill for the average American to swallow.

Next we come to Health Care delivery. Well, we know who will deliver Health Care, we will, you and I. With maybe some help from the nurse practitioners and others, but primarily us. The question is, whether our patients will continue to have the freedom to

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### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 7 JULY 1994

### Unity

Think back to the time when you first joined MSMA. What process took place?

Did a written notice in the mail bring you to your first local component society meeting? Probably not.

Chances are your partner or a doctor friend cornered you one day and said "hey, you ought to come go with me to the Medical Society meeting tonight. We'll have a great meal and a good time."

And you went. And you joined. And now here you are.

But, where are you?

Sure there are a lot of physicians who belong to MSMA, but the majority on our rolls are merely passive observers of things these days. Quite frankly, I find it hard to be passive about the goings-on in medicine today.

The medical profession can no longer afford to hang back at home, in our offices, and with our noses to our respective grindstones and let the rest of society dictate our futures.

We had all better be interested and informed, and be about the business of minding our business, because there is a world of folk out there chomping at the bit to mind it for us. The 1994 MSMA meeting had a very simple but powerful theme - UNITY. A resolution calling for "de-unification" was unanimously defeated on the floor on Sunday morning. (For those of you not in attendance, the term "de-unification" refers to a resolution to drop the requirement that every member of MSMA also be a member of the AMA.) If you don't like that, well, I guess you should have been there.

Vice-speaker George McGee commented that "the take home message is....take the message home."

Tonight, get out your handy MSMA membership directory. (You know....that really neat book with everyone's picture in it.) There are some pull out pages that came with it, a list of Mississippi MD's who are <u>not</u> members of the MSMA. Reading the list is an eye-opener.

There are about 750 names there. The names of some of your classmates appear on this list. There are some inactives and retirees. One or two names I recognize are now deceased. There are a few who are currently actually practicing out of state and there are newcomers to the state. There is an inordinate number of UMC professors.

You get the idea. Read the list. I'm certain you will see the name of someone you know well, someone that you didn't realize was not a member.

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The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

choose their own physician or will the proposed alliances start picking and choosing who will be allowed to participate therefore leaving perhaps some physicians and some patients out in the cold. Or forcing the patient to choose a new physician. Will the basic package be all inclusive or will there be limitations. If there are to be limitations, as only seems reasonable from a financial standpoint, who has to tell the patient and his/her family that there is a treatment available but it's not part of their basic package, Big Brother or us? Does the Health Care Czar (whoever it may be) do this or will it again be pushed off on the physician — and who is liable if that patient suffers or dies because a treatment was withheld since it wasn't in the basic package?

This leads up to the legal and legislative reform needed to make these plans work. Will the American public get relief from seeing one third or more of any judgements awarded in a malpractice suit going directly into a trial lawyer's pocket and will the American physicians see a relief from frivolous law suits filed by trial lawyers on a contingency basis just to "test the waters" and see if they can get a settlement? How about the unjust collateral source rule and outrageous amounts being sought for "non-economic" damages? Legislatively, will there be anti-trust relief so that the health care providers (the physicians) can negotiate reasonable fees for themselves with any health alliance, or if not, some mechanism to prevent the health alliances from undercutting one physician against another until we are all forced to leave the practice of medicine?

Make no mistake, Health Care Reform is coming. Even if it follows Sen Rostenkowski's "transitional period", and if he isn't in jail by the time this is published. In fact, Health Care Reform is already here. Hospitals are buying up physicians practices in some parts of the state, HMOs are starting to move into Mississippi and MSMA itself has formed our Mississippi Physicians Care Network to deal with health alliances, the self insured (ERISA) programs and the state government employees. Yep! Health Care Reform is here and we need to work together to do our best to make it the least traumatic to our patients and ourselves (and I believe that is best done through organized medicine) or we will all suffer.

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If you do, give them a call. Invite them to the next quarterly meeting of your component medical society. Feel them out, get their opinions. Why don't they belong?

At MSMA this year we learned about the "Member-Get-A-Member Program." If you are interested, the MSMA will provide you with invitations and materials to help you bring in new members. But, a personal conversation actually works best. I'll wager you remember who invited you or took you to your first meeting.

The MSMA is a wonderfully diverse group. It is filled with folks with brilliant minds and superlative talents from all specialties. We doctors as a rule are such independent creatures! We tend to bicker among ourselves endlessly. We think of our individual selves as always being right and always knowing what's best for everybody. Ergo, if your opinion is different from mine, well by golly, you must be wrong!

Unity....how can a group of men and women as different and as headstrong as we all are possibly be united about anything? If we remember that this group has one singular and very noble purpose at its core, then we can. That single-minded goal should be this....to always provide for our patients the best medical care we possibly can. If we can agree that this one thing is what we're really all about, then friends, we've got it made.

Ladies and Gentlemen of the MSMA....talk is cheap, let's go home and act.

Dwalia South, MD Associate Editor



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Robert Ferguson Joplin, Mississippi



Evelyn Hunley Jackson, Mississippi

To the Editor, Journal MSMA:

Please allow me to take this opportunity to express my appreciation to the membership of the Mississippi State Medical Association for the privilege of serving as associate editor of the MSMA Journal for the past six years. The experience has been a rich and rewarding one for me, and I hope that I have in turn provided some useful input to the membership in general and to the Journal in particular. It has, indeed, been a pleasure to work with Dr. Myron Lockey and the Journal staff.

I wish for my successor, Dr. Dwalia South, a successful tenure, and for the Journal a bright future.

Sincerely,

George E. Abraham, II, MD

Editors note: The Following letter is reprinted from the Voice Of The People Column of the Commercial Dispatch, Columbus, MS.

Thanks For The Presentation:

On behalf of the Columbus Municipal School District I would like to thank the Mississippi State Medical Association and Alliance and the Lowndes County Medical Alliance for their joint sponsorship of a children's forum on the negative effects of alcohol, tobacco and other drugs.

The forum was held March 30 on the campus of MUW and featured a dynamic 90-minute presentation by JeVon Thompson of Olympia, Washington. I attended this conference and witnessed 850 Columbus School District 5th and 6th graders, along with students from Lowndes County and other schools in the community, actively listening and participating in this program.

This was truly an outstanding and worthwhile educational experience for our students.

Again, thanks to the Mississippi State Medical Association and Alliance and the Lowndes County Medical Alliance for their support.

Sincerely, Reuben E. Dilworth, Superintendent Columbus Municipal School District

### Dear Colleagues:

I deeply appreciate the Association and the MSMA Alliance making the \$10,485 contribution to the AMA-ERF in my name.

AMA-ERF funds have been an invaluable resource for our School of Medicine throughout its history and truly have helped provide the "margin for excellence" for medical education in Mississippi. To have my name associated with this major gift is an honor in which I will always take enormous pride.

Warmest personal regards.

Sincerely,
Norman C. Nelson, MD
Vice Chancellor for Health Affairs and
Dean, School of Medicine



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COUNCIL ON MEDICAL EDUCATION:  Chair (Dist. 2 - 1996)	COUNCIL ON SCIENTIFIC ASSEMBLY Chair (1995)
(Dist. 8 - 1997)	YOUNG PHYSICIANS SECTION: Chair (1995)

JULY 1994 211

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# **New Members**

Adkins, Todd N., Jackson. Born May 4, 1962 in Meridian, MS; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year University Medical Center, Jackson, MS; internal medicine residency, same, 1989-92; fellowship in allergy & immunology, St. Louis University Health Sciences Center, St. Louis, MO, 1992-94; elected by Central Medical Society.

Archer, Brian S., Hattiesburg. Born Akron, OH, February 18, 1964; MD, Northeastern Ohio Medical Center, Akron, OH, 1989; internal medicine residency, same, 1990-93; elected by South Mississippi Medical Society.

Brantley, Shelby K., Jr., Jackson. Born Carthage, MS, May 18, 1961; MD, University of Mississippi School of Medicine, Jackson,

MS, 1987; one year general surgery, same; plastic surgery residency, same, 1989-1990 and plastic surgery residency, University of Tennessee College of Medicine, 1992-94; elected by Central Medical Society.

Christian, Claiborne A., Southaven. Born Richmond, VA, July 22, 1960; MD, Medical College of Virginia, Virginia Com-



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### American Academy of Pediatrics



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The American Academy of Pediatrics is working to improve health-care for children, adolescents and young adults. As part of the effort, the nation's 45,000 pediatricians have declared October as Child Health Month. Join us this month as we speak up for children. Help us place solutions before problems.

- Before it's too late, vaccinate. Check your records. Immunize your child on time.
- See a pediatrician regularly. Vaccination is just one very important part of your child's total health care. Make sure you have a regular doctor or clinic that knows your child. Get regular checkups even when your child is not sick.
- Good nutrition helps keep your child healthy. Be sure your child eats regularly, has a variety of nourishing food choices, and gets plenty of exercise.

For more information, send a business sized, stamped, self-addressed envelope to: *Disease Prevention*, Dept. C, American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60009-0927.

monwealth University, Richmond, VA, 1986; orthopaedic surgery residency, Campbell Clinic, Memphis, TN, 1987-91; fellowship in sports medicine, University of Florida, Gainesville, FL, 1991-92; elected by Desoto County Medical Society.

Deal, Roy W., Pascagoula. Born in Topeka, KS, November 27, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; residency in psychiatry, Vanderbilt University Hospital, Nashville, TN, 1986-89; elected by Singing River Medical Society.

Ellis, Dunk A., Moss Point. Born New Orleans, LA, December 5, 1955; MD, Meharry Medical College School of Medicine, Nashville, TN, 1987; family practice residency, same, 1987-90; elected by Singing River Medical Society.

Haidar, Ahmad A., Picayune. Born Lebanon, July 15, 1953; MD, University of Guadalajara, Mexico, 1982; internal medicine residency, Medical Center, Harrisburg, PA, 1989-93; elected by Pearl River Medical Society.

Hicks, Gilliam Swink, Jr., Jackson. Born Natchez, MS, February 24, 1950; MD, University of Mississippi School of Medicine, Jackson, MS, 1975; interned one year, UMC, Jackson, MS; internal medicine residency, VA Hospital, Jackson, MS, 1975-78; elected by Central Medical Society.

Kennedy, Grace L., Macon. Born Liberia, West Africa, July 21, 1961; MD, Medical College of Pennsylvania, Philadelphia, PA, 1985; family practice residency, Franklin Square Hospital, Baltimore, MD, 1985-88; elected by Prairie Medical Society.

LaBonte, Roger S., Southaven. Born October 25, 1941; MD, University of Tennessee College of Medicine, Memphis, TN, 1983; interned one year, same; internal medicine residency, same, 1984-86; elected by Desoto County Medical Society.

Loper, William E., III, Ridgeland. Born Gulfport, MS, September 5, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; family practice residency, University of Alabama School of Medicine, Montgomery, AL, 1986-89; elected by Central Medical Society.

Martin, Reginald W., Jackson. Born Chicago, IL, March 12, 1964; MD, Meharry Medical College School of Medicine, Nashville, TN, 1988; interned one year, University of Louisville School of Medicine, Dept. Surgery, Louisville, KY, 1988-89; surgery residency, same, 1989-93; elected by Central Medical Society.

Matthias, Heddy D., Jackson. Born Oneida, NY, April 17, 1950; MD, Tufts University School of Medicine, Boston, MA, 1977; internal medicine residency, same, 1978-80; anesthesiology residency, Albany Medical Center, Albany, NY, 1984-86; critical care fellowship, University of Pittsburgh Health Science Center, Pittsburgh, PA, 1980-81; elected by Central Medical Society.



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Medical Underwriters of Mississippi P.O. Box 535 • 215 South Jackson Brookhaven, Mississippi 39601 604-833-2441 The Charlie Williams Insurance Agency 311 East Main Street Senatobia Mississippi 38668 601-562-4040 McClaln, Donald Allan, Jackson. Born Fayetteville, NC, February 15, 1951; MD, Cornell University Medical College, New York, 1979; interned one year, Stanford University Medical Center, Palo Alto, CA, 1982-83; internal medicine residency, same, 1983-85; fellowship in endocrinology, University of California., San Diego, CA, 1985-87; elected by Central Medical Society.

Moore, Marvina L., Jackson. Born Oklahoma City, OK, May 20, 1961; MD, Oklahoma State University College of Osteopathic Medicine, Tulsa, OK, 1989; anesthesiology residency, Medical College of Georgia, Augusta, GA, 1990-93; elected by Central Medical Society.

Morgan, Mark W., Bay St. Louis, Born New Orleans, LA., September 27, 1963; MD, Louisiana State University School of Medicine, New Orleans, LA, 1989; interned in internal medicine, University of Tennessee, Memphis, TN, 1989-90; anesthesiology residency, Tulane Medical Center, New Orleans, LA, 1990-93; elected by Coast Counties Medical Society.

Poltka Marshall B., Hattiesburg. Born Birmingham, AL, April 23, 1954; MD, Duke University School of Medicine, Durham, NC, 1980; interned two years, University of Utah College of Medicine, Burlington, UT, 1980-82; elected by South Mississippi Medical Society.

Powell, June A., Corinth. Born Benton County, February 3, 1943; MD, University of Mississippi School of Medicine, Jackson, MS, 1968; psychiatry residency, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, NC, 1975-78; elected by Northeast Mississippi Medical Society.

Puneky, Louis V., Jackson. Born October 18, 1959; MD, Louisiana State University School of Medicine, New Orleans, LA, 1985; interned and internal medicine residency, University Medical Center, Jackson, MS, 1985-88; fellowship in oncology, same, 1988-90 and fellowship in hematology, University of Alabama at Birmingham, AL, 1990-91; elected by Central Medical Society.

Smith, Gary L., Jackson. Born Meridian, MS, January 11, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned one year, same; anesthesiology residency, University of Louisville, Louisville, KY, 1990-91 and University Medical Center, Jackson, MS, 1991-93; elected by Central Medical Society.

Spears, Hubert E., Jr., Oxford. Born Grenada, MS, October 8, 1955; MD, University of Mississippi School of Medicine, Jackson, MS, 1980; surgery residency, University of Tennessee, Memphis, TN, 1980-85; fellowship in surgical oncology, Roswell Park Memorial Cancer Institute, Buffalo, NY, 1985-87; elected by North Mississippi Medical Society.

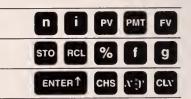
Thompson, Robert F., Jr., Tupelo. Born Oxford, MS, May 25, 1961; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; internal medicine residency,

Methodist Hospital, Memphis, TN, 1987-91; anesthesiology residency, Louisiana State University Medical Center, New Orleans, LA, 1991-93; elected by Northeast Mississippi Medical Society.

Wineland, Herbert Lee, Gulfport. Born Gunnison, CO, October 30, 1946; MD, Tulane University School of Medicine, New Orleans, LA, 1974; ob-gyn residency, Tulane & Charity Hospital of New Orleans, LA, 1974-77; elected by Coast Counties Medical Society. □

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### **Personals**

Kenn Beeman, of Tupelo has been certified by the American Board of Thoracic Surgery.

Roger M. Bradford has associated with Paul M. Pavlov, and Richard H. Smith in North Bay Family Medical Clinic, 10495 Lemoyne Blvd., D'Iberville.

Eric Mason Dyess of Meridian has been named a Fellow of the American College of Endocrinology (ACE), the educational and research arm of the American Association of Clinical Endocrinologist (AACE).

Clifton Cartwright and Leonard Pratt are joining their practices to form the Boonville Family Practice Clinic.

Lee Giffin of Vicksburg, spoke on AIDS to medical assistants attending the recent State Podiatric Meeting held in Vicksburg.

Benton Hilbun, of Tupelo has been appointed to a 6 year term on the MS State Board of Medical Licensure beginning, July 1, 1994.

J. Eimer Nix of Jackson has recently been selected to serve on the Committee on Ethics of the American Academy of Orthopaedic Surgeons.

Thomas G. Puckett, Medical Director and Chief Executive Officer at Puckett Laboratory in Hattiesburg, presented Puckett Laboratory as a Model of Laboratory Integration at a recent conference held at Mayo Medical Laboratories, in Rochester, Minnesota.

Michaei A. Seicshnaydre, of Gulfport. a specialist in ear, nose and throat medicine and surgery, has been board certified by the American Board of Otolaryngology.

Richard Sharp of Tupelo has received board certification from the American Board of Physical Medicine and Rehabilitation.

Clyde Sheehan of Tupelo has received board certification by the American Board of Psychiatry and Neurology.

Timothy Thompson of New Albany recently attended *The Fourth Annual Southeastern Conference's Sports Medicine Symposium*, sponsored by the Southern Medical Association.

William S. Turner of Hattiesburg has been certified as a Diplomate in Psychiatry by the American Board of Psychiatry and Neurology.

H. Lee Wineland has associated with Richard A. Nicholls, and The Center for Gynecology and Obstetrics, 3091 Bienville Blvd., Ocean Springs.

Mickey P. Wallace, a facial plastic surgeon in Jackson, has been named a fellow of the American Academy of Facial Plastic and Reconstructive Surgery. (AAFPRS).

Correction: June Issue, p. 188 Louis V. Puneky, will associate with Jackson Oncology Associates, 1190 N. State Street, Suite 501, Jackson, July 1, 1994.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments. We encourage you to send notices to:

Personals Column Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 354-4834.

# Physicians' Recognition Award

Twenty-four MSMA members were named recipients of the AMA Physicians Recognition Award in April and May 1994. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY
Virgil Isaac Aultman, MD
Kenneth Gilbert Carter, MD
R. Deaver Collins, MD
Charles Decherd Guess, MD
Earl Leslle Mahaffey, MD
Clyde Ray McLaurin, MD
Victor Wade Yawn, MD

CLARKSDALE AND SIX COUNTIES
MEDICAL SOCIETY
Michael S. Ballentine, MD
Frank T. Marascalco, MD

COAST COUNTIES MEDICAL SOCIETY SIdney Albert Chevis, MD

DELTA MEDICAL SOCIETY

James Vaiden Ferguson, MD

EAST MISSISSIPPI MEDICAL SOCIETY
Edward Lester Carruth, MD
Walter D. Gunn, MD
Francls E. Harman, MD
Eddie Clay Starnes, MD

NORTH MISSISSIPPI MEDICAL SOCIETY

Dwalia S. South, MD

NORTH CENTRAL MISSISSIPPI MEDICAL SOCIETY Wirt F. Shrock, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY Kelly S. Segars, MD

PRAIRIE MEDICAL SOCIETY Leonard H. Brandon, MD Albert Henley Laws, MD

SINGING RIVER MEDICAL SOCIETY Donald Edward Doyle, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY Rickey Lynn Chance, DO Word McDonald Johnston, MD Eugene Linwood Shannon, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

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# Meetings

#### NATIONAL AND REGIONAL

American Medical Association, Annual Meeting, June 10-15, 1995 Chicago; Interim, December 4-7, Honolulu, HI. James S. Todd, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

#### STATE AND LOCAL

Mississippi State Medical Association, Jackson, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Academy of Family Physicians, Leontine Stevens, Executive Secretary, PO Box 1215 Ridgeland 39158.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, MD, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: Ms. Jenkins, PO Box 4053, West Station, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, David
 G. Hall, MD, Secy., 150 Jeff Davis Blvd, Suite 130, Natchez 39120.
 Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Gary Holdiness, MD, 332 Hwy 12 W, Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Richard L. Heyer, Jr., MD, Secy., Mail: Ms. Shirley Irwin, PO Box 3294, Tupelo 38803-3294. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Catherine E. Gleason, MD, Secy., 1306 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, Joseph S. Boggess, MD, Secy., 515 Willowbrook Rd., Columbus, MS 39701. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Hal Moore, MD, Secy., Mail: Ms. Beverly Small, 3003 Shortcut Rd, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George,

Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Chester Masterson, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

# Mississippi Institutions and Organizations Accrediated for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials of the Accrediation Council for Continuing Medical Education (ACCME)" and the Council on Medical Education of the MSMA. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39202-1166

North Mississippi Medical Center 830 Gloster Street Tupelo, MS 38801

Forrest General Hospital Mamie Street and Highway 49 South Hattiesburg, MS 39401

Mississippi Baptist Medical Center 1225 N. State Street Jackson, MS 39202

Gulf Coast Community Hospital 180 DeBuys Rd. Biloxi, MS 39531

Natchez Regional Medical Center Seargeant Prentiss Drive Natchez, MS 39120

King's Daugthers Hospital Highway 51 North Brookhaven, MS 39601

Biloxi Regional Medical Center 150 Reynoir St. Biloxi, MS 39533

Jeff Anderson Regional Medical Center 2124 14th St. Meridian, MS 39301

Methodist Medical Center 1850 Chadwick Dr. Jackson, MS 39204

Grenada Lake Medical Center 960 Avent Drive Grenada, MS 38901

Golden Triangle Regional Medical Center 2520 Fifth St., North Columbus, MS 39701 Northwest Mississippi Regional Medical Center Hospital Dr. Clarksdale, MS 38614

Singing River Hospital 2809 Denny Ave. Pascagoula, MS 39567

Greenwood Leflore Hospital 1401 River Rd. Greenwood, MS 38930

Memorial Hospital at Gulfport 4500 13th St. Gulfport, MS 39501

Baptist Memorial Hospital of North Mississippi Highway 7, South Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital 969 Lakeland Dr. Jackson, MS 39216

Delta Regional Medical Center 1400 E. Union Greenville, MS 39704

Methodist Hospital 5001 W. Hardy St. Hattiesburg, MS 39401

MS State Department of Health PO Box 1700 Jackson, MS 39215-1700

Rush Foundation Hospital 1314 19th Avenue Meridian, MS 39301

# 1993 Summary Mississippi Youth Risk Behavior Survey

Weighted Data • N = 1,394 • Overall Response Rate = 83%

#### INTENTIONAL AND UNINTENTIONAL INJURY

43 % Rode with a drinking driver during past month
39 % Were in a physical fight during past year
28 % Carried a weapon during past month
18 % Always wore seatbelts
10 % Attempted suicide during past year

### **TOBACCO USE**

76 % Ever smoked cigarettes
28 % Smoked cigarettes during past month
12 % Used smokeless tobacco during past month

#### **ALCOHOL AND OTHER DRUGS**

78 % Ever used alcohol
47 % Used alcohol during past month
27 % Consumed 5 or more drinks in a row during past month
21 % Ever used marijuana
2 % Ever used cocaine
2 % Ever used steroids
1 % Ever injected IV drugs

#### **SEXUAL BEHAVIOR**

Ever had sexual intercourse
 Used a condom during last sexual intercourse (among sexually active students)
 Had 4 or more sexual partners during lifetime
 Used birth control pills during last sexual intercourse (among sexually active students)

### **DIETARY BEHAVIORS**

38 % Trying to lose weight32 % Thought they were overweight

### **PHYSICAL ACTIVITY**

77 % Were not enrolled in physical education class
 18 % Attended physical education class daily
 17 % Exercised more than 20 minutes per physical education class

Source: MS Youth Risk Behavior Survey (grades 9-12) • MS State Department of Education • Mr. I. D. Thompson (601) 359-3915

# **Placement Service**

Jounal MSMA Placement and Classified ads cost \$2.00/line, with a 4-line minimum charge of \$8.00. There are approximately 50-characters per line in 11 point TR type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

Journal MSMA Display Classified ads cost \$75.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camara-ready materials are preferred. Typeset ads are available for an additional charge.

Items should be sent to:

Placement Service or Classified Section Journal MSMA, PO Box 5229, Jackson, MS 39296-5229

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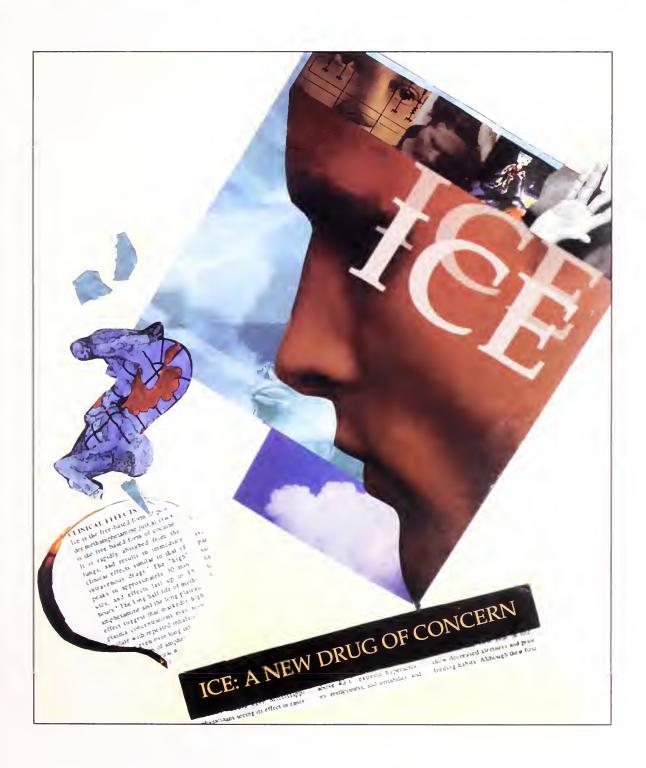
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**SCIENTIFIC ARTICLE** 

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### **Dateline**

# Journal of the Mississippi State Medical Association Volume XXXV, Number 8

### AMA & Girl Scouts Announce Mentoring Program

Chicago, IL — The American Medical Association (AMA) announces a new national program designed to increase interest in medicine as a career -- The Physicians of Tomorrow Mentoring Program. The program has been developed by the AMA Advisory Panel on Women Physician Issues in cooperation with the Girl Scouts of the USA (GSUSA). It will link medical societies from across the country with the local girl scout councils/troops in a hands-on project for Cadet and Senior Girl Scouts (age 14 to 17). Participating girl scouts can explore their interests in medicine through an independent study project and by working with a woman physician mentor assigned by the medical society. Local medical societies have a unique opportunity to participate in this exciting program which will be officially launched in September during Women in Medicine Month.

There are now over 100,000 women physicians in the US, 20% of all physicians, a dramatic increase from a little over ten years ago when only 11% were female. This growth will continue. Nevertheless, there may continue to be young women who will not pursue a career in medicine due to a lack of encouragement and/or of women physician role models. The Physicians of Tomorrow Mentoring Program will reach out to young women at a crucial age when they are making decisions and choosing paths that will profoundly affect the rest of their lives. The program focuses on building confidence and self esteem in young girls and providing opportunities for women physicians to provide direct support and encouragement to those potential physicians of tomorrow.

For further information about The Physicians Of Tomorrow Mentoring Program contact, Phyllis Kopriva, Director of AMA Women in Medicine Services, at 312-464-4392.

\*\*\*

MFMC Conducts
"Quest for Quality"
Workshop on
September 7.

Jackson, MS — MFMC will conduct "Quest For Quality", a workshop for Administrators, Physicians and Quality Assurance Staff, on Wednesday, September 7, at the Lakeover Center off Watkins Drive and I-220 in Jackson.

The program will address various aspects of quality, including its definition and measurement; quality improvement plan specifics and development; updates on special quality projects underway at MFMC; and potential projects.

The program will feature a physician sharing his experiences in the development of practice guidelines, as well as the experience of a Mississippi hospital in developing a patient care pathway.

Registration begins at 8:30 a.m. with the program starting at 9 a.m. and concluding around 3 p.m. There is a \$15 fee to cover the cost of the noon luncheon.

For more information, call 601-354-0304

\* \* 1

### **Original Article**

### ICE - A New Drug of Concern?

DIANE K. BEEBE, M.D. ELIZABETH J. WALLEY, M.S.Ed.

Methamphetamine has long been a drug of abuse. Recently, a resurgence of its use has spread across the country. A smokable form of methamphetamine hydrochloride with the street name "ice" has spread eastward from Hawaii and California. It has strong stimulant properties, is twice as toxic as amphetamine, is associated with multiple system effects similar to cocaine. Treatment of acute intoxication is symptomatic and may include hydration, temperature regulation, seizure management, control of agitation, and monitoring for cardiac arrhythmias. Long-term treatment of addiction requires drug rehabilitation and inpatient counseling.

National figures on drug abuse report that in 1988, 64 percent of high school seniors indicated they could easily obtain amphetamines. Between 1986 and 1988, the National Institute on Drug Abuse reported a 1.7-fold increase in emergency department evaluations for methamphetamine abuse.2 The Drug Abuse Warning Network (DAWN) system, which includes selected hospitals within 21 metropolitan areas, reported 3,030 methamphetaminerelated emergency department visits in 1988.3 Complete figures on the use of "ice" smokable methamphetamine hydrochloride, are not available due to its relatively new emergence.

Methamphetamine has been reported to be the most abused drug in San Diego County, California, accounting for 60% of the illicit drug seizures by law enforcement, and up to 40% of treatment center referrals.4 Figures

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from San Diego County, California, reveal 32 methamphetaminerelated deaths in 1987. This compares to 66 cocaine-related deaths. There were 10 deaths involving both methamphetamine and cocaine.5 Ice, or crystal, has recently become a drug of abuse in certain areas of this country, most notably in Hawaii, Southern California, and along the Pacific coast.6,7 Introduced in the United States in the early 1980's 8 its eastward spread across this country could have Mississippi physicians seeing its effect in emergency departments and offices. Recent arrests in Copiah County have, in fact, been made regarding the alleged sale of crystal methamphetamine.9 Little literature exists on this drug form, but it is felt to have originated in Korea and the Philippines.6 A Southern California report compares the cost of ice to crack without mentioning a dollar amount.10 Anecdotal accounts from Mississippi teenagers indicate that a typical rock of cocaine approximately the size of a pencil eraser costs twenty dollars. Ice, if comparable in cost, is an inexpensive drug and, therefore, accessible to many people.

#### **CLINICAL EFFECTS**

Ice is the free-based form of powder methamphetamine just as crack is the free-based form of cocaine. It is rapidly absorbed from the lungs and results in immediate clinical effects similar to that of intravenous drugs. The "high" peaks in approximately 30 minutes, and effects last up to 15 hours. The long half-life of methamphetamine and the long plateau effect suggest that markedly high plasma concentrations may accumulate with repeated inhalation of the drug even over long

intervals.11

As a form of amphetamine, ice is a strong central nervous system (CNS) stimulant. Direct stimulation of the peripheral nervous system and of organs may also occur. The clinical effects of ice are similar to other stimulants such as cocaine. High doses may cause irreversible CNS damage.

Acutely, users report experiencing euphoria, intensified emotions, increased alertness, altered self-esteem, and increased sexuality.7 Initial presentation may include hyperpyrexia, with temperatures above 40° C, extreme hyperactivity, restlessness, irritability, and acute toxic psychosis, with auditory hallucinations and extreme paranoia. Destructive behavior is frequent.<sup>6,7</sup> Medical complications most commonly involve the cardiovascular system. Chest pain, usually without electrocardiographic changes, tachycardia, palpitations, dyspnea, hypertension, myocardial ischemia, and atrial and ventricular arrhythmias have occurred. 6,7 Acute pulmonary edema has developed 24 to 36 hours following inhalation.12 In addition, vasospasm resulting in acute myocardial infarction, cardiogenic shock, and death has been reported.2 Other systemic effects include mydriasis, cerebral edema, hemorrhage (Subarachnoid, Intraventricular, Intracerebral), 6.13,14 hyperpyrexia, elevated serum thyroxin level,13 hyperactivity, rhabdomyolysis, 2 anorexia, weight loss, and malnutrition.6,13

Chronically, users may exhibit symptoms indistinguishable from paranoid schizophrenia with delusions, paranoia, and aggressive behavior. 6,15 This induced psychosis has been shown to resolve within ten days of cessation of the drug; however, in 10% of patients it may persist for up to

six months. After resolution, readministration of the drug may induce recurrent psychosis in a shorter period of time than initially. Fatalities have been reported with doses of 1.5 mg per kilogram; however, doses up to 15,000 mg per kilogram may be tolerated in long-term abusers.

Transplacental exposure to methamphetamine is an increasing problem with effects similar to that of cocaine exposure. These include intrauterine growth retardation, decreased head circumference, placental hemorrhage, preterm labor, fetal bradycardia, meconium, and neonatal anemia. Infants, in the first year of life, show decreased alertness and poor feeding habits. Although their first year development is generally normal, most infants have minor neurologic abnormalities. By he time children reach school age, some frontal lobe dysfunction may be apparent. A child's developmental course is not predictable based on neonatal assessment.4

#### MANAGEMENT

To minimize sensory stimulation, patients should be kept in a quiet room. They should be well hydrated and receive volume replacement.7 Cardiac monitoring for is essential.13 arrhythmias Haloperidol (Haldol) should be used for control of agitation. Hypertension with diastolics of 110 mm of mercury or greater may be managed with intravenitroprusside.6 nous Chlorpromazine (Thorazine) and intravenous propranolol (Inderal) have also been recommended for lowering blood pressure and controlling agitation.13 Diazepam (Valium) is the drug of choice for initial seizure management, although uncontrolled seizures may warrant use of phenytoin (Dilantin) or phenobarbital. Cooling blankets and cool water sponging are appropriate for hyperthermia. Urine acidification with intravenous ammonium chloride or oral ascorbic acid may hasten the elimination of amphetamine but may not be clinically helpful.<sup>6</sup> Urine acidification is contraindicated if myoglobinuria is present since it may accelerate this condition. In these cases, urine alkalinization is recommended.<sup>13</sup>

Withdrawal symptoms include abdominal cramping, gastroenteritis, headache, lethargy, dyspnea, and severe depression with suicidal tendencies. These may peak within two to three days. Long term treatment requires drug rehabilitation and intense inpatient counseling.

2500 North State Street Jackson, MS 39216-4505

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- rotations in the field of Addiction Medicine.
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### **Special Article**

#### THE BIG BAD WOLF

Is Your House Made of Bricks?

ERIC E. LINDSTROM, JR., J.D., LL.M TAX JOHN K. DRISDALE, JR., J.D. Drisdale & Lindstrom P.A. Attorneys & Counselors



#### DEATH, TAXES AND LAWSUITS

Everyone has heard the old idiom "the only thing certain in life are death and taxes." Physicians face another "almost" certainty - sometime during their life they will be sued. The number of lawsuits against physicians has steadily increased over the last 15 years. Recent studies indicate that one in three Mississippi physicians will be sued, with some specialists facing a 100% chance of being sued. This trend, which expands medical legal liability, results from the current mindset we call "The Liability Society."

This article focuses on using non-U.S. jurisdictions as part of your family wealth planning to reduce your "victim quotient" to our legal system. However, since inertia is the most effective enemy to planning, we will first address some common misconceptions that foster complacency.

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#### THE THREE MYTHS

- 1. THE LEGAL SYSTEM WILL BE REFORMED.
- 2. ONLY BAD PEOPLE ARE SUED.
- 3. JUSTICE WILL PREVAIL IF I GET SUED.

THE FIRST MYTH THE LEGAL SYSTEM WILL BE REFORMED.

The United States is unique as one of the few jurisdictions that permits "contingency fee" lawsuits. Proponents argue charitable and noble reasons for contingency fee lawsuits. However, other forces may be at work. One explanation offered by Forbes magazine is that "suing for damages has become... a huge industry." The "business" of contingency fee lawsuits was the focal point in a recent article published in The Clarion Ledger highlighting the Inner Circle of Advocates Club, a lawyer's club limited to personal injury lawyers with large jury awards. Estimated annual incomes of these attorneys were reported to range between \$5 and \$10 million, and one attorney reportedly made over \$500 million in a single case.

Over the past several years, there have been numerous efforts to reform the legal system. Why do these reformers continually meet with defeat? One explanation is that the beneficiaries of the system are wealthy, politically strong and very intelligent. The economics of this "huge industry," combined with the general public's perception of physicians as wealthy, creates ideal conditions for effective lobbying. Mississippi is not insulated from the problem either. One Mississippi senator was recently quoted as saying: "If you're for the big money doctors, vote for this [tort reform] amendment. If you're for the people of this state, vote against it." The proposed amendment was defeated.

THE SECOND MYTH ONLY BAD PEOPLE ARE SUED.

If this myth is true, then the medical profession is populated with "bad people." The economics of con-

tingency fee lawsuits and the perception of physicians as wealthy target defendants better explains the disproportionate number of lawsuits against physicians. Lawsuits have skewed the costs of practicing medicine. These costs, also referred to as the "Tort Tax," have grown at a compound rate of 12% since World War II. The American Medical Association estimates that for every \$1 spent on insurance premiums, physicians spend \$2.70 on additional tests and recordkeeping, driving the estimated costs of these lawsuits to \$184 billion in 1991.

THE THIRD MYTH JUSTICE WILL PREVAIL IF I GET SUED.

A lawsuit is filed based on the plaintiff's, not the defendant physician's, version of the facts. In most cases, the lawsuit is filed with minimal cost to the plaintiff.<sup>7</sup> Unlike the defendant physician who has only downside risk - personal anguish, litigation costs and the possibility of financial ruin, the plaintiff has minimal litigation costs and tremendous upside potential - a large judgment. While it is true that most cases do settle, it is only after the defendant has incurred significant expenses, with the reasons for settlement seldom related to being "right" or "wrong." Frequently, those physicians who go to trial and win the "battle" later discover that the overall litigation costs resulted in losing the "war."

## THE SOLUTION: AMERICAN STYLE WARFARE

History can teach those willing to learn. Since the United States has an "adversarial" legal system, military analogies are both appropriate and enlightening. The American Revolution provides an excellent example. The British, with extensive resources, had developed a certain military style. Marching in straight lines, the first line of the brightly dressed British forces would fire its volley, return to the back lines for re-loading while the second line would advance, fire its volley and repeat the pattern. In contrast, the American colonists would, in an ungentlemanly but effective fashion, shoot from behind trees, rocks and other obstacles, thus making

themselves elusive targets in their drab clothing.

To date, physicians have been fighting like the British forces. As high profile targets clad in their colorful insurance policies and personal bank accounts, physician casualties have been heavy. Indeed, their opponents have been successful in their "hit and run" guerilla tactics against the individual physicians and, absent a change, the outcome of this war is predictable. However, what if, in effect, physicians were to hide behind trees and rocks? What if physicians made themselves more elusive and formidable so that plaintiffs would seek easier targets?

#### OFFSHORE ASSET PROTECTION: CHANGING THE EQUATION

Simply stated, asset protection is reducing your attractiveness as a "target" defendant. Asset protection techniques should not be implemented alone, but should be part of your overall family wealth planning. Too often, however, family wealth planning is limited solely to minimizing estate taxes, which completely ignores the fact that litigation risk can dwarf estate tax savings. Using non-U.S. jurisdictions avoids the major limitations of "domestic" asset protection arrangements employed by many practitioners. Just as different states may be used to create a "Mississippi" corporation or a "Delaware" corporation, different countries may be used to protect your assets. Although legal analysis of various tax and other issues is required, using offshore jurisdictions can increase a plaintiff's litigation costs and, at the same time, increase the physician's chances of winning. Some of the common questions clients ask are as follows:

What Are the Advantages of Offshore Jurisdictions? One major advantage is the ability to invest in foreign investment funds with outstanding track records. Many "offshore" fund managers are former U.S. fund managers who, with success, have relocated their operations to avoid extremely expensive U.S. regulatory requirements. Another major advantage is the superior asset protection of non-U.S. jurisdictions which create many obstacles for plaintiffs not faced in the U.S., including:

 laws that do not recognize U.S. judgments (a U.S. judgment is ignored!);

- short statutes of limitations (unlike the recent Mississippi case<sup>9</sup> that allowed a patient to sue his physician 23 years later);
- a prohibition against contingency fee lawsuits (the plaintiff must now pay legal fees just like you);
- no basis for physician liability under the non-U.S. jurisdiction's laws; and
- in some cases, bonding requirements for plaintiffs equal to 20% of the claimed damages (in other words, a plaintiff seeking \$10 million would be required to deposit \$2 million with the court before being allowed to sue).

Is it Legal? Yes. Many clients assume that offshore jurisdictions are corrupt and drug-infested. Actually, most offshore jurisdictions have branches of the largest banks in the world with some boasting over 400 branches of established banks. In our experience, these bankers are more worried than their U.S. counterparts about the character of the clients who seek their services. They do not need or want clients engaged in drug activities or tax fraud since they have plenty of legitimate paying clients.

Which Offshore Jurisdiction Is Best? Numerous offshore jurisdictions exist. Some of the more popular include the Bahamas, Belize, Bermuda, British Virgin Islands, Cayman Islands, Channel Islands, Cook Islands, Cyprus, Gibraltar, Isle of Man, Liechenstein, Turks and Caicos. The actual choice of an offshore jurisdiction depends on many factors including language, type of legal system, proximity, and business infrastructure.

Is Timing Important? Yes! Timing is extremely important since asset protection planning is effective only against <u>future</u>, not pending, lawsuits and claims. Asset protection must be implemented <u>before</u> a claim arises.<sup>10</sup>

Conclusion. Physicians no longer need to live in fear of losing everything to a plaintiff. Through the use of proper legal planning, there are alternatives to being a victim of the legal system.

#### References and Notes:

- Proponents argue that the cost of litigation would prevent the "poor" from having access to justice.
- 2. "The Tort Tax", Forbes Feb. 17, 1992 (p. 40 et seq.).
- Membership is limited to those who have won at least 50 cases and have at least one judgment or settlement in excess of \$1 million to his or her credit. "'Thanks a Million' Has a Special Meaning for Lawyer's Club,"

- The Clarion Ledger (1/29/94), p. 11 ("Thanks a Million").
- Contingency fee plaintiff attorneys typically receive between one-third and two-thirds of the judgment collected. Thanks a Million, id.
- 5. Lawyer's Weekly p. A-18 (Feb. 28, 1994).
- 6. "The Tort Tax,", fn. 2, supra.
- 7. In contrast, once sued the defendant physician must hire an attorney and the expenses begin. Frequently, the expenses are paid by the physician's malpractice carrier. However, a premium increase will be forthcoming, and the anxiety heightens for physicians facing claims that exceed insurance limits.
- 8. Settlement reasons include insurance coverage, jury unpredictability, fear of "20-20 hindsight" being applied to the diagnosis and treatment, extensive physician time required to defend a lawsuit, emotional stress, and the effect of press coverage on the physician's reputation.
- 9. For an in-depth discussion of the William v. Kilgore decision by the Mississippi Supreme Court, see T. L. Smith, Jr., Saved by Grace, Raised From the Dead: A Claim for Medical Malpractice Experiences Religious Awakening (Mar. 9, 1993).
- 10. One client of the authors had not undertaken any asset protection before a contingency fee plaintiff's attorney filed suit alleging \$15 million in damages in an area of unsettled law. In settlement negotiations, the client asserted his lack of fault and, indeed, it seems likely that a jury would have agreed since the facts were very favorable. The contingency fee attor-

ney then clarified his position. He acknowledged that, in his own opinion, he had less than a 10-15% chance of winning. However, he stated that he also knew that he could cause our client to incur six-figure legal expenses, a couple of years of time and trauma in defending a lawsuit, and once in front of the jury he could roll the dice for \$15 million. The contingency fee attorney concluded his remarks by saying that it was "nothing personal, just business." After settling the lawsuit for an amount approaching the estimated attorney's fees, the client then implemented asset protection arrangements.

Drisdale & Lindstrom P.A. focuses on family wealth planning, offshore asset protection, business and non-litigation law practice. Eric Lindstrom holds a Masters of Laws degree in Taxation from New York University, is currently serving on the Executive Committee of the Mississippi State Bar Section of Taxation, and is a member of the American Institute of Certified Public Accountants. A member of the Mississippi and Texas Bars, John Drisdale has personally interviewed various offshore banks, trustees, and attorneys over the last several years in connection with asset protection planning. Readers with questions may contact the authors at P.O. Box 13329, Jackson MS 39236-3329; MS WATS: 800-710-7833 or (601) 982-5599 in Jackson. Listing of the previously mentioned areas of practice does not indicate any certification of expertise therein.

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# A REFERRAL SOLUTION FOR PHYSICIANS WITH SPECIAL UROLOGICAL CASES

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CHARLES L. SECREST, M.D.

Dr. Secrest received his B.A. degree from the University of Mississippi, and earned his medical degree from the University of Mississippi School of Medicine. He completed his internship and residency in General Surgery at Baylor University Medical Center in Dallas, Texas; served a residency in Urology at the University Medical Center in Jackson, Mississippi; and a fellowship in Adult and Pediatric Reconstructive Urology at Eastern Virginia graduate school of Medicine in Norfolk, Virginia.



JAMES E. KEETON, M.D.

Dr. Keeton received his B.A. degree from the University of Mississippi and his medical degree from the University of Mississippi School of Medicine. He completed his internship and urology residency at University Medical Center, in Jackson, Mississippi. Dr. Keeton served a fellowship in Pediatric Urology (Senior Registrar) at the Hospital for Sick Children in London, England; and a fellowship in Urology (Clinical Assistant) at the Middlesex Hospital in London.

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The President's Page MALLAN G. MORGAN, MD

## A Book Review of "Fatal Cure" by Robin Cook G. P. Putman's Sons, 1994

In Robin Cook's new book "Fatal Cure", David and Angela Wilson are young physicians who are just finishing their residencies, in Internal Medicine and Pathology, respectively. They decide to go to a small town in Vermont, Bartlett, to enter private practice. David goes to work for a HMO, Comprehensive Medical Vermont (CMV), while Angela signs up with the Bartlett Community Hospital. Initially, everything is perfect. But then David's patients who have been admitted for easily treatable illnesses start to die unexplainably. Angela also begins to have problems at the hospital (read the book, I'm not going to tell you everything!). In typical Robin Cook fashion, things go from bad to worse, not only for the patients but also for the Wilsons.

"Fatal Cure" seems to refer to what is happening to David's patients but it also a comment on the effect of managed care on patient care in this country. A double entendre if you will. There are numerous references to the effects of managed care not only on physicians, but also comments on how the current environment could affect hospitals.

Dr. Caldwell, medical director of the Bartlett Hospital, says "It's not easy these days running a hospital, especially in this era of government-mandated competition. Revenues are down, costs are going up. It's hard just to stay in business." Later, characters in the book comment on how they hope a certificate of need for open heart surgery, sought at the desire of the HMO, would be denied since the hospital

(Continued on page 236)

#### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 8 AUGUST 1994

#### Liability, Again

Just when you thought you had a grip along comes the report from Congress's Office of Technology Assessment. This office studied the effects of physicians' liability fears as they ordered diagnostic tests and therapy. The report concludes that such fears have only a minor effect on doctors' ordering habits and the resulting cost of medical care.

Well, now that's news. Here all this time I've been mistaken about my own motivations. And my colleagues! All their bitter talk on the problem has apparently been nothing more than the wild babblings of the deluded. But the report goes on. It says doctors vastly over estimate their chances of being sued, and—get this—that these exaggerated fears serve the useful purpose of preventing doctors from cutting back on needed tests in the face of cost control pressures.

How could we have been so wrong? The answer is that we're not. A glimpse of the bureaucrats' attitude comes when they try to explain why no dollar figure could be placed on the cost of defensive medicine. "Virtually impossible," the report says, sinc; physicians may not respond truthfully when asked about their own clinical practices.

If these staffers would bring their heads up out of the sand for even a few minutes they would have to look no further than President Clinton to see the havoc wreaked by even one lawsuit. The President is now forced to beg for a legal defense fund, his political career and personal life facing devastation from Paula

Jones's lawsuit. And this for the man to whom the trial lawyers devoted their largess in the last election campaign and who pointedly kept tort reform out of the Health Security Act. No one, it seems, is safe. Even sympathetic presidents are expendable for the sake of such a lucrative system.

Government naivete over the tort crisis is not limited to the Office of Technology Assessment. Two years ago Dr. David Kessler's Food and Drug Administration threw gasoline on the fire of product liability by removing silicone breast implants from the market on the basis of scare and anecdote about links to autoimmune illness. Several recent studies, virtually the only published epidemiologic work, have failed to demonstrate a link. This comes after companies defending the cascade of lawsuits that followed the FDA's action have put up \$4.3 billion into a settlement

(Continued on page 238)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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#### President's Page

(Continued from page 234)

had a capitation contract with the HMO. Open heart surgery would mean more admissions and longer stays, costing the hospital more with no increase in revenue from the HMO. Good P.R. for the HMO, easier access to care for patients, but a financial nightmare for the hospital. Or, if denied, bad for the patients but good for the hospital's bottom line.

From the HMO's standpoint, their administrator admits, "whether the hospital loses money or not is not CMV's concern". At a meeting of the HMO administrator, the hospital CEO, and the chairman of the hospital's board of trustees, It was recognized that "Something just occurred to me. Here we've had this high level meeting that could possibly determine the fate of the hospital and there were no doctors present." The CEO replied, "It's a sign of the times. The burden of dealing with the health care crisis has fallen on us administrators. I think it's the medical world's equivalent of the expression, 'War is too important to leave up to the generals,'" answered the chairman of the board.

Now, from the doctor's viewpoint, David is called to the HMO's administrator's office and told that his "productivity is not satisfactory." The administrator goes into his number of patient visits per hour, number of laboratory tests per patient, number of consultations requested from outside the HMO (remember, he has had a rash of unexplained patients deaths), and the number of emergency room visits by his patients. At one point David is told that the emergency room is only for life or death emergencies. When he asks how the patients are supposed to know if its life or death until they are seen, and if he is overloaded, tied up, and cannot see them immediately, what are they to do, if not go to the E.R. After all, he asks, "then what's the E.R. for?" He is told not to be a "wise ass." It seems that the E.R., the ambulance service, as well as the "outside" consultants have to be paid separately by the HMO. And after all, to the HMO, the bottom line is health system profit, not health care. The HMO administrator, as David reflected, never mentioned quality of care or patient approval.

David's comment to Angela was "The problem is Washington. Every time the federal government gets seriously involved in medical care they seem to screw it up. They try to please every body and end up pleasing no one. Look at Medicare and

Medicaid; they're both a mess and both have had a disastrous effect on medicine in general."

As the plot thickens and more of David's patients die, he tells Angela, "More pressure from CMV...I have to avoid talking to patients and answering their questions. I wonder if the patients realize they are being shortchanged?" Again, David was told he was asking for too many consultations, ordering too many lab tests and diagnostic tests, even though his patients were dying unexplainedly. He felt like it was the inquisition. "He was being tried for economic medical heresy, and not one of his inquisitors was a physician."

In the final chapter, after the solution of the mystery, Dr. Cook has David Wilson say, "In many health plans, doctors are being rewarded with bonuses not to hospitalize or not to treat in some specific way." His wife, Angela, states, "It should be the patient's needs that determine the level and type of treatment." Dr. David Wilson concludes, "I've learned that it is dangerous to allow financial and business people and their bureaurocrats to interfere in the doctor-patient relationship."

Of course, this is all fiction and admittedly, I hope, a worse case scenario. But if its not.....





## PRO Workshops Planned for September 9 & 14

The Mississippi Foundation for Medical Care will conduct PRO Update Workshops on September 9 in Oxford and September 14 in Hattiesburg.

The workshops will be held at the Holiday Inns in Oxford and Hattiesburg. The programs will update Medicaid/Private review; Medicare review criteria; and the health care quality improvement program.

Registration at each site will begin at 8:30 a.m., with the updates starting at 9 a.m. The workshops will conclude around noon and there is no charge to attend.

For more information, call 601-354-0304.



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Mississippi Physicians Insurance Company offers employers worker's compensation coverage exclusively. We focus all our efforts on how to "provide" workers' comp coverage rather than simply "writing it". We are the specialist in this field.

#### **Editorial**

(Continued from page 235)

fund, one billion of it to be the contingency fee for a few dozen lawyers. Breast implants are, of course, harder to come by these days for mastectomy patients.

It should not have to be stated that the FDA's job is to evaluate products using the scientific method, not to lead the hysteria. With these goings on it is hard to imagine tort reform coming from the federal government. And where will it all end? Not

here, anyway. That menacing dust cloud on the far side of the ridge and the thundering diesels you hear is another trial lawyer armored column on the attack. The new objective, one every bit as obscure as the silicone breast implant case, is a disease called RSI. Not SBE, PAT, RA or BPH—that's RSI. The attorneys can tell you it stands for repetitive stress injury, and it is now the subject of over 3,000 lawsuits. I don't need to tell you that the link between a computer keyboard and wrist or neck pain is murky at best. But as an attorney representing over a thousand RSI plaintiffs was recently quoted as saying, "The law can't wait on science."

Leslie E. England, MD
Associate Editor

## SURGEONS: COULD YOU USE AN EXTRA \$9,000?

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#### **COMMENTS**

On page 137 of the May 1994 issue of the Journal of the Mississippi State Medical Association, Chairman of the Council on Medical Service Dwalia South, MD called for MSMA member's opinions on Nurse Practitioners in the State of Mississippi. Following are some of the letters received.

Dr. South:

Having worked with nurse practitioners for nineteen years, I feel eminently qualified to comment on their practice. I do believe that nurse practitioners can be a valuable part of a medical team. However, I feel that for them to practice independently can be dangerous. It is my opinion that a physician should be physically present on site at least 30% of the time the mid level is practicing and preferably this should be split into two different days during the week. Additionally, the nurse practitioner should have available contact with a physician by phone at all times.

The role of a nurse practitioner plays should be understood by all and followed meticulously by the practitioner. I have seen several nurse practitioners providing inappropriate care, caring for patients with diseases and levels of illness outside the competency of the nurse practitioner and fail-

ing to order appropriate tests.

Ultimately, malpractice and poor practice rests directly on the shoulders of the precepting physician. This problem is causing concerns for other competent, conservative nurse practitioners including the one currently working with me. Nurse practitioners are ideally suited to provide care for simple acute illness and to monitor care for chronic illness which is stable. My major concern is the nurse practitioner, who is expanding her practice outside these areas without proper physician support and supervision.

If I can be of any further assistance, please do not hesitate to contact me.

Sincerely, Linda Chidester, MD Mantachie

(Comments continued on page 240)

COMMENTS or QUERIES.... The Editors of Journal MSMA invite members of the MSMA to comment for publication on any material that appears in the publication or on other current medical issues. If you have a comment or query, please send it to: The Editors, Journal MSMA, PO Box 5229, Jackson, MS 39296-5229.

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Dr. South:

It was a pleasure to have met you at the State Medical Association meeting. I am impressed with your ability to articulate verbally and now in writing since I have read your letter about nurse practitioners. Dr. Richardson, a family practitioner from Louisville, made a comment in front of the house of delegates on Sunday about the problem of nurse practitioners moving into the area of primary care and being reimbursed at levels higher than physicians are currently reimbursed for Medicaid patients. Apparently there is a lot of lobbying going on by nurse practitioners to increase their scope of practice. I saw a long article on the McNeil-Lahrer report just last night which was very much biassed in favor of the nurse practitioners. Obviously, the person who put the article on was approached by the nurse practitioners and mostly heard their side of the story. They made a statement that nurse practitioners make less than half of physicians for seeing the patient. Obviously this in not true for Medicaid patients in our State. We need to get these facts out to counter the erroneous statements. It seems to me that there must be some MD's who are making a lot of money sponsoring these nurse practitioners. In my community, the physicians do not seem to be supervising the nurses since they refer patients directly to me, an ear, nose and throat specialist, without ever discussing it with the physician supervisor. We need to look out for the nurse practitioners to try to legislate themselves a medical license.

> Sincerely, Joe Boggess, MD Columbus

MSMA 127th Annual Session Scientific Assembly

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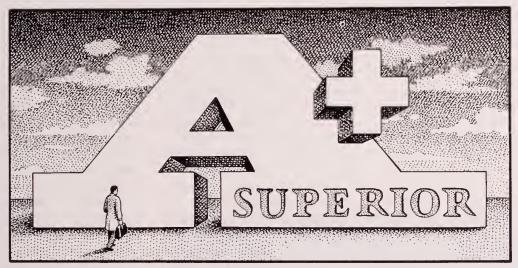
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## **Medical Organization**

## Dr. J. T. Davis of Corinth Dies at Age 89

Dr. J. T. Davis, Sr., died Tuesday, July 5, at Baptist East Hospital in Memphis, after a brief illness.

The son of the late George and Sallie Rinehart Davis, Dr. J. T. Davis was born in Columbus and reared on a dairy farm in Corinth. After graduating from Corinth High School, he attended Vanderbilt University where he received his bachelors degree in chemistry in three years. It was his fraternity brothers who encouraged Dr. Davis to enter medical school and his patients who reaped the rewards.

Dr. W. A. White, III, chief of staff at Magnolia Hospital, summed up what many in the community feel, "Dr. J. T. is a man you can call 'great.' He practiced medicine in an exemplary fashion but his influence is this community went even deeper than that. The contributions he made cannot be measured only by the successes of his family — which are significant."

Dr. White went on to add that "You have to take into account too, the influence he had on lots of us, including me. He was the big reason I decided to become a doctor. He and I shared a lot of background at Vanderbilt and I still strive to come up to his high standards."

In an article in the August

1989 edition of *The Daily Corinthian*, Dr. Davis talked about his practice. Although he was a general surgeon, specializing in delicate hand surgery, he broadened his responsibilities performing many techniques from delivering babies to setting bones. For almost six decades, Dr. Davis served the local community making house calls or whatever was needed to help his patients, even in an age when such personal service had become a rarity.

For those interested in pursuing a career in medicine, Dr. Davis; had four things he advised students to consider: "If you're looking for the best education you can get, study medicine. If you like people study, study medicine. If you're willing to accept at least 50 percent of your compensation for your gratitude from your patients, study medicine. If you're looking forward to getting wealthy by studying medicine, forget it."

Dr. Davis was an active member of First Baptist Church for 74 years. He received his medical degree from Vanderbilt Medical School and completed his internship and surgery residency at Cleveland City Hospital, Cleveland, Ohio, and at the same time met his wife, Mary. After four years the couple returned to Corinth where he set up a practice before leaving for World War

II. He served four years in Europe in the Army Surgical Corps and achieved the rank of lieutenant colonel.

After resuming his practice as a general surgeon, Dr. Davis published a number of papers on surgery of the hand.

Dr. Davis was a member of the American College of Surgeons; President of the Mississippi State Medical Association, 1974-75; a member of the Board of Trustees of MSMA, 1964-73; Chairman of the Board of Trustees of MSMA, 1971-73; President of the Mississippi Foundation for Medical Care, 1971-74 and President of the Mid-South Medical Association, 1969-70. He was also president of the Corinth Kiwanis Club; and director and organizer of Emergency Medical Services at Magnolia Hospital. Dr. Davis served as chief of staff at Magnolia Hospital and as president of the Alcorn Medical Society.

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## Mini-internship Gives Group Inside View of Health Care

A group of businessmen and elected officials recently got an "inside view" of the health care delivery system in Jackson County.

Physicians of the Singing River Medical Society invited eight individuals to take part in a two-day pilot project "mini-internship," during which participants made rounds with doctors, observed surgical operations, spent time in the Singing River Hospital Emergency and Radiology Departments, and followed the participating physicians through half a day of office visits.

"In today's health care environment of spiraling costs, confusion, litigation and health care reform, the Singing River Medical Society feels that its members can better respond to the concerns of the community through establishment of ongoing and open communication vehicles," said Dr. Richard Whitlock, family practitioner, who is president of the Singing River Medical Society and a member of the Singing River Hospital medical staff.

"Our mini-internship program is an effort to achieve these ends by sharing the humane concerns of physicians and health care providers through first-hand experience with the selected interns," Dr. Whitlock explained.

Interns were chosen and invited by the Medical Society based on their positions as decision makers in industry and government. Those "interns" participating in the first group included representatives of International Paper Company, members of the Mississippi House of Representatives, Mississippi Power Company, a member of the Singing

River Hospital System Board of Trustees and SRHS's physician recruiter.

The mini-internship included a Sunday evening orientation dinner, two days of internship, and a wrap-up session on Tuesday night where the interns and physicians could discuss the experience and share impressions.

The interns went through fourhour rotations in four of five distinct medical fields: Primary Care, Surgery, Emergency Medical Care, Radiology and Urology.

The concept of the mini-internship is a new idea being implemented by a number of health care associations nationwide, according to Dr. Whitlock. "A program such as this accomplished many goals," he said.

"Number one, it spotlights the patient/physician relationship. Number two, it opens valuable lines of communication and develops understanding between decision makers and the medical community. Number three, it stimulates a self-examination and awareness among us as physicians to help identify problems and make improvements in the health care delivery system."

Singing River Medical Society with its more than 90 members throughout Jackson County, plans conduct additional mininternships in the future.

#### **Evers Award Winner**



Patrick Hugh Scanlon, Jr., of Jackson received the Carl Gustav Evers Award at School of Medicine honors day at the University of Mississippi Medical Center. The Mississippi State Medical Association Foundation award is given to a senior medical student who has demonstrated qualities of scholarship, peer-to-peer support, and exceptional leadership in student activities of the American Medical Association and the Mississippi State Medical Association. The award was presented by Dr. Don Q. Mitchell, second from right, Dr. Norman C. Nelson, right, UMC vice chancellor for health affairs at UMC, and Mrs. Jan Evers, widow of the late Dr. Carl Evers whom the award honors. Dr. Ever's children, Gus, Julie and Karen were also on hand.

#### Jackson Student Recognized at UMC



James Morrison Fuller, Jr., of Jackson, center, was among students recognized for academic achievement during the annual awards day ceremonies for the School of Medicine at the University of Mississippi Medical Center in Jackson. Dr. Norman C. Nelson (left) is UMC vice chancellor. Dr. Don Q. Mitchell (right) immediate past president of the MSMA presented the award. Fuller, a third-year UMC medical student, was recognized as the recipient of the Dr. Virginia Stancil Tolbert Award given for academic excellence and leadership.  $\square$ 

## **Dr. Boggan Honored For Years Of Service**

Austin P. Boggan, MD, a family physician in Decatur was recently honored with an appreciation banquet for service to his town and community from 1954-1994. The celebration of Austin P. Boggan's life, service and dedication to his fellow man was the focal point of not only the banquet but also a reception at the Newton County Court House.

The entire weekend, under the leadership of the Decatur Chamber of Commerce, culminated the efforts of the area to show Dr. Boggan the regard and love of area residents, as well as patients.

Dr. Boggan was presented an engraved plaque from the town of Decatur stating the appreciation for 40 years of service and an award plaque for service to the community.

The high point of the evening was the announcement of the Austin P. Boggan Scholarship fund at East Central Community College. The scholarship was created through contributions from individuals and businesses to honor Dr. Boggan.



JOURNAL MSMA

#### Central Medical Alliance Wins National Health Award

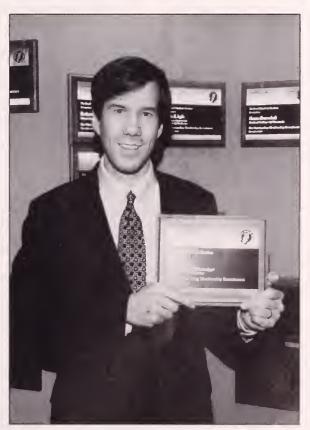


Receiving the award for Central Medical Alliance are Jane Ladner, left, Chairman, Blake Clinic Project and Kathy Fletcher, center, Central Alliance immediate past president.

Peggy Crawford, right, MSMA Alliance immediate past president accepted the award which was presented during the Alliance Annual Convention in Chicago on behalf of Central Medical Alliance.

Central Medical Alliance received the American Medical Association Alliance, Inc., 1994 Health Promotions Award for their work with the Blake Clinic. The award presented during the June Alliance meeting in Chicago was for a Medical Alliance sponsored Health Education Program or Action Project.

Providing medical assistance to children with physical handicaps and special health care needs is the purpose of The Blake Clinic; helping to make the clinic a better, more inviting place has become a primary mission of the Central Medical Alliance. Through fund-raisers and donations of cash and goods, the Alliance has raised \$15,000 to improve the physical appearance of the clinic. It has also worked to keep legislators aware of the clinic's needs and services, and most importantly, to bring cheer into the lives of the clinic's children through such events as an annual Christmas party.  $\Box$ 



During the AMA Annual Meeting, Jim Fuller, a UMC M4, received the AMA Medical Student Section recognition award for Outstanding Membership Recruitment. He was also selected by the AMA's Board of Trustees as the medical student representative on the AMA Council on Legislation...

## The University of Mississippi Medical Center

#### UMC Faculty Promotions Announced

Thirty-three faculty in the Schools of Medicine, Dentistry, Nursing and Health Related Professions at the University of Mississippi Medical Center have received promotions.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced the promotions, effective July 1, following approval by the Board of Trustees of State Institutions of Higher Learning.

Promoted to the rank of professor in the medical school were Dr. A. Wallace Conerly and Dr. Valee Harisdangkul (medicine), Dr. James A. Joransen (pediatrics), Dr. Connie S. McCaa (ophthalmology), Dr. Robert A. McGuire (orthopedic surgery), and Dr. Bharti R. Patel (radiology).

Medical school faculty appointed to associate professor included Dr. Diane K. Beebe (family medicine), Dr. L. Susan Buttross (pediatrics), Dr. Richard W. Finley (medicine), Dr. William B. Geissier (orthopedic surgery), Dr. Christina Glick (pediatrics), Dr. Terrence J. Hall (surgery), Dr. Louis Harkey (neurosurgery), Dr. Daniel W. Jones (medicine), Dr. W. Marcus Meeks (medicine), Dr. Rathel L. Nolan (medicine), Dr. Donald J. Raggio (pediatrics), Dr. Edward F. Rigdon (surgery), Dr. William E. Roberts (ob-gyn), and Dr. Charles G. Sherwood (ophthalmology).

Centerwide faculty promoted to professor were Dr. Victor L. Davidson (biochemistry) and Dr. Robin W. Rockhold (pharmacology and toxicology). Appointed to associate professor were Dr. March D. Ard (anatomy), Dr. James B. Hutchins (anatomy), Dr. Robert E. Kramer (pharmacology and toxicology), and Dr. Manis J. Smith, Jr. (physiology and biophysics).

In the dental school, Dr. M. Kevin O' Carroll (diagnostic sciences) and Dr. Lyle D. Zardiackas (orthopedic surgery) were appointed to professor.

In the School of Health Related Professions, Dr. J. Maurice Mahan (interdisciplinary and cooperative education) and Dr. Robert Weaver (physical therapy) were promoted to the rank of professor. Promoted to associate professors were Bette Groat (occupational therapy) and Patsy Hester (occupational therapy).

Dr. Conerly directs the Department of Respiratory Therapy in University Hospital. A member of the Medical Center faculty since 1973, he has served as the assistant vice chancellor for health affairs since 1981. Dr. Conerly will succeed Dr. Norman C. Nelson, who will retire Aug. 1, as vice chancellor for health

affairs and dean of the School of Medicine. He earned the MD in 1960 at Tulane University and took his internship at the McLeod Infirmary at Florence, S.C., and U.S. Air Force School of Aerospace Medicine at Brooks Air Force Base, Texas. He did a fellowship in medicine in the Section on Cardiology at Ochsner Foundation Hospital in New Orleans, then took a residency in medicine at the Medical Center.

Dr. Harisdangkul, a rheumatologist, has been a faculty member since 1979. She earned the MD at Siriraj Hospital Medical School in Bangkok, Thailand, and the PhD at Columbia University in New York. She completed residency training at UMC and rheumatology fellowships at the Hospital for Special Surgery at Cornell University in New York and the Department of Medicine at the Michael Reese Medical Center in Chicago.

A pediatric cardiologist, Dr. Joransen earned the MD at Baylor University. He completed his internship at Ben Taub General Hospital in Houston, residency in pediatrics and a fellowship in pediatric cardiology at the University of Minnesota Hospital in Minneapolis. He has been a member of the faculty since 1972.

Dr. McCaa directs research in the Department of Ophthalmology. A member of the faculty since 1963, she earned the PhD and the MD and completed internship and residency at UMC.

Dr. McGuire is the director of spine surgery in the Depart-

ment of Orthopedic Surgery. A faculty member since 1990, he earned the MD at the University of Alabama School of Medicine in Birmingham and completed internship and residency training at Naval Hospital in Portsmouth, Virginia. Dr. McGuire also completed fellowships in the Spinal Cord Injury Unit and Adult Spine Surgery at the University of Miami School of Medicine and Pe-Reconstruction diatric Scoliosis at Miami Children's Hospital.

Dr. Patel directs the Nuclear Medicine Division. She joined the faculty in 1981. Dr. Patel earned her medical degree and completed internship and residency training at the University of Baroda, India. She also completed surgery residency at UMC, residency in pathology at Elyria Memo-

rial Hospital in Elyria, Ohio and a nuclear medicine fellowship at MallincKrodt Institute of Radiology at Washington University.

Dr. Davidson, a faculty member since 1988, earned the PhD at Texas Tech University in Lubbock, Texas.

Dr. Rockhold joined the UMC faculty in 1983. He earned the PhD at the University of Tennessee Center for Health Sciences in Memphis. Dr. Rockhold completed postdoctoral research fellowships at the Institute of the University of Heidelberg in West Germany and the University of Tennessee Center for the Health Sciences.

A member of the faculty since 1976, Dr. O' Carroll directs oral radiology. He earned his degree in dentistry at the National University of Ireland and the MSD at Indiana University School of Dentistry. He is a fellow of the American Academy of Dental Radiology.

Dr. Zardiackas, the director of biomaterials, has been a faculty member since 1979. He earned the MS and the PhD at the University of Virginia.

Dr. Mahan, a member of the faculty since 1977, is the dean of the School of Health Related Professions. He earned the MS at Bucknell University and the PhD at the University of Illinois.

Dr. Robert Weaver has been a member of the faculty since 1987. He earned the MBA at Kent State University, the MAEd at the University of Akron, the PhD at the University of Southern Mississippi and the BS at UMC.



Philip Merideth, MD, psychiatric resident at the University of Mississippi Medical Center, has been selected as a 1994-1995 Rappeport Fellow.

Chosen by the Rappeport Fellow-ship Committee of the American Academy of Psychiatry and the Law (AAPL), Dr. Merideth will receive a year's membership in AAPL, which includes subscrip-



tions to the AAPL Bulletin and Newsletter, an expensepaid trip to the AAPL annual meeting in Maui, Hawaii in October, and free tuition to participate in the Forensic Psychiatry Review Course, prior to the meeting.

A native of Greenville, Dr. Merideth holds degrees in law and medicine from the University of Mississippi.

#### LAB Animal Facilities Approved

The University of Mississippi Medical Center's (UMC) Laboratory Animal Facilities (LAF) were inspected by the USDA Animal and Plant Health Inspection Service on June 23. The University's facilities and programs were found to be in full regulatory compliance.

"This is an important step toward our goal of attaining AAALAC (American Association for Accreditation of Laboratory Animal Care) accreditation for all Medical Center animal programs," said Dr. Norman C. Nelson, UMC vice chancellor of health affairs. "The LAF staff and animal-based research personnel are to be commended on this excellent report."

#### SHRP Department Changes Name

As of July 1, the Department of Interdisciplinary and Cooperative Education in the School of Health Related Professions at the University of Mississippi Medical Center, became the Department of Health Sciences. The new name reflects a recent inrease in the emphasis of the department on the health and social sciences, administration and management.  $\square$ 

## Mississippi Magazine's Premier House to Benefit Children's Hospital

Tourgoers who purchase a ticket to wander through the halls of Mississippi Magazine's 1994 Premier House also will be making a contribution to Children's Hospital.

The Bryan Company, a locally based, real estate development organization, is building the Premier House to showcase the architecture of J. Carson Looney, AIA, the interior design talent of Ann Carter, and the artistic landscaping of landscape architect Tom Bobbitt. The show home at Windrose Point, a secluded waterfront community on the eastern shore of the Ross Barnett Reservoir, will be fully furnished with merchandise from some of Mississippi's top retailers.

Proceed from ticket sales go to help build the Children's Hospital. Tickets can be purchased for \$5 at the door of The Premier House. The home will be open for touring 11 a.m. - 6 p.m. Saturday, September 17, Monday-Saturday, September 19-24, and Monday -Wednesday, September 26-28.



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JOURNAL MSMA

#### **Personals**

Todd Adkins has associated with the Mississippi Asthma & Allergy Clinic, P.A. for the diagnosis and treatment of asthma and allergic diseases, 940 North State Street, Jackson.

W. J. Anderson, III, announces the relocation of his office to 2024 15th Street, 5th floor, Suite B, Medical Towers Building, Meridian.

Shelby K. Brantley, Jr., has associated with Plastic Surgery Associates, for the practice of plastic and reconstructive, hand, cosmetic, and head and neck surgery, 971 Lakeland Drive, Suite 515, Jackson.

Charles Ronald Brent announces the relocation of his practice in neurological surgery to South Mississippi Neurological Services, P.A., 710 South 28th Avenue, Suite C, Hattiesburg.

Peter J. Casano has associated with The Head and Neck Surgical Group, for the practice of ear, nose, throat, head and neck, and facial plastic surgery, 1038 River Oaks Drive, Flowood.

Sidney A. Chevis of Bay St. Louis has completed continuing medical education requirements to

retain active membership in the American Academy of Family Physicians (AAFP).

A. Wallace Connerly, assistant vice chancellor for health affairs at UMC, has been appointed the American College of Chest Physician's Commissioner to the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

Samuel J. Creekmore of New Albany has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFP).

Randy Easterling, a family practice physician at The Street Clinic in Vicksburg, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFP).

Scott P. Guidry has associated with the Hattiesburg Clinic in the practice of general surgery, 415 South 28th Avenue, Hattiesburg.

Van Lackey, of Jackson, a graduate of UMC School of Medicine has been elected president of the Medical Alumni chapter for the Alumni Association.

Murphy S. Martin has associated with Central Nephrology Clinic, P.A. for the practice of nephrology and dialysis, 1856 Hospital Drive, Jackson.

Martin McMullan of Jackson has been elected UMC Guardian Society chairman and will serve from March 1994 to March, 1995.

C. Jason Miller, has associated with The Newborn Group, Methodist Medical Center, Mississippi Baptist Medical Center, Jackson.

Richard C. Miller, professor of surgery and associate dean at UMC was named recipient of the Arthur A. Derrick Award by the Mississippi Foundation for Medical Care during the 23rd annual session.

C. Michael Osborne, has associated with William F. Sneed and Ralph Sneed, emeritus, at the Jackson, Ear Nose & Throat Clinic, for the practice of ear, nose, and throat surgery, pediatric ENT and head and neck surgery, 1421 N. State Street, Suite 402, Watkins Medical Bldg., Jackson.

Herman T. Palmer affiliating his medical practice with Baldwyn Family Medical Clinic, 745 High-

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage you to send notices to: Personals Column Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 354-4834.

## Meetings

#### NATIONAL AND REGIONAL

American Medical Association — Interim, December 4-7, 1994, Honolulu, HI; Annual Meeting, June 10-15, 1995, Chicago; Leadership Conference, April 23-26, 1995, Washington; Interim, December 3-6, 1995, Washington. James S. Todd, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

#### STATE AND LOCAL

Mississippl State Medical Association — Annual Meeting, May 17-21, 1995, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, MD, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: Ms. Jenkins, PO Box 4053, West Station, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, David
 G. Hall, MD, Secy., 150 Jeff Davis Blvd, Suite 130, Natchez 39120.
 Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Gary Holdiness, MD, 332 Hwy 12 W, Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Richard L. Heyer, Jr., MD, Secy., Mail: Ms. Shirley Irwin, PO Box 3294, Tupelo 38803-3294. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Catherine E. Gleason, MD, Secy., 1306 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, Joseph S. Boggess, MD, Secy., 515 Willowbrook Rd., Columbus, MS 39701. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Hal Moore, MD, Secy., Mail: Mrs. Lujean Trumble, P. O. Box 231, Pascagoula 39568-023. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Chester Masterson, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

#### Mississippi Institutions and Organizations Accrediated for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials of the Accrediation Council for Continuing Medical Education (ACCME)" and the Council on Medical Education of the MSMA. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39202-1166

North Mississippi Medical Center 830 Gloster Street Tupelo, MS 38801

Forrest General Hospital Mamie Street and Highway 49 South Hattiesburg, MS 39401

Mississippi Baptist Medical Center 1225 N. State Street Jackson, MS 39202

Gulf Coast Community Hospital 180 DeBuys Rd. Biloxi, MS 39531

Natchez Regional Medical Center Seargeant Prentiss Drive Natchez, MS 39120

King's Daugthers Hospital Highway 51 North Brookhaven, MS 39601

Biloxi Regional Medical Center 150 Reynoir St. Biloxi, MS 39533

Jeff Anderson Regional Medical Center 2124 14th St. Meridian, MS 39301

Methodist Medical Center 1850 Chadwick Dr. Jackson, MS 39204

Grenada Lake Medical Center 960 Avent Drive Grenada, MS 38901

Baptist memorial Hospital - Golden Triangle 2520 Fifth St., North Columbus, MS 39701 Northwest Mississippi Regional Medical Center Hospital Dr. Clarksdale, MS 38614

Singing River Hospital 2809 Denny Ave. Pascagoula, MS 39567

Greenwood Leflore Hospital 1401 River Rd. Greenwood, MS 38930

Memorial Hospital at Gulfport 4500 13th St. Gulfport, MS 39501

Baptist Memorial Hospital of North Mississippi Highway 7, South Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital 969 Lakeland Dr. Jackson, MS 39216

Delta Regional Medical Center 1400 E. Union Greenville, MS 39704

Methodist Hospital 5001 W. Hardy St. Hattiesburg, MS 39401

MS State Department of Health PO Box 1700 Jackson, MS 39215-1700

Rush Foundation Hospital 1314 19th Avenue Meridian, MS 39301

Charter Hospital of Jackson East Lakeland Drive Jackson, MS 39296-4297

#### Personals/continued

## Physicians' Recognition Award

ILII

Eight MSMA members were named recipients of the AMA Physicians Recognition Award in June 1994. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY
Billy L. Walker, MD

DELTA MEDICAL SOCIETY Arthur W. Wood, MD

East Mississippi Medical Society John J. Davis, MD A. Patrick Sprabery, MD William Martin Wood, MD

Northeast MS Medical Society Samuel J. Creekmore, MD Francis G. Fidei, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY Victor E. Landry, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

way 45 South, Baldwyn on July 1, 1994.

Randall Kirk Reid, has associated with Jackson Anesthesia Associated, for the practice of anesthesiology, 1151 N. State Street, Suite 508, Jackson, MS 39202.

Seth Scott has associated with George County Hospital and Community Medical Center for family practice.

Arthur Eugene Wood, Jr. of Inverness has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians (AAFP).



#### **Placement Service**

Journal MSMA Placement and Classified ads cost \$2.00/line, with a 4-line minimum charge of \$8.00. There are approximately 50-characters per line in 11 point TR type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

Journal MSMA Display Classified ads cost \$75.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camara-ready materials are preferred. Typeset ads are available for an additional charge.

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EM, FP, GP, GS, IM, PD, OB, ORS needed in Alabama, the Southeast, and nation-wide. Please send CV to PO Box 70910, Tuscaloosa, AL 35407, or call 800-543-6050.

MSMA
127th Annual Meeting
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And because all design specifications are permanently stored in the computer, future modifications are swift and accurate. That means we can spend more time helping your patients rebuild their lives, instead of just rebuilding their bodies.

A Division of the Mississippi Methodist Rehabilitation Center 1350 Woodrow Wilson, Jackson, MS 39216

To make a referral or schedule a CAD/CAM demonstration, call 601 981-2611 or 800 223-6672.

SEPTEMBER 1994





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A Division of the Mississippi Methodist

A Division of the Mississippi Methodist Rehabilitation Center 1350 Woodrow Wilson, Jackson, MS 39216

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# JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

SEPTEMBER 1994

SCIENTIFIC ARTICLE

**VOLUME XXXV** 

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or policies of the Mississippi State Medical Association.

#### Hospital Medical Staff Section 24th Assembly Meeting December 1-5, 1994 Sheraton Waikiki Hotel Honolulu, Hawaii

#### Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

#### Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Mahalo!



## **Dateline**

## Journal of the Mississippi State Medical Association Volume XXXV, Number 9

## POWER Network Hotline Open

# Staying up-to-date on the Washington health system reform debate is a challenge of all us. The situation in Congress changes daily -- sometime hourly.

To make it easy for you to get the latest information, the AMA has created a toll-free POWER (Physicians Organized to Work for Effective Reform) Network Hotline. The hotline gives daily, up-to-theminute updates on House and Senate action on health system reform.

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\* \* \*

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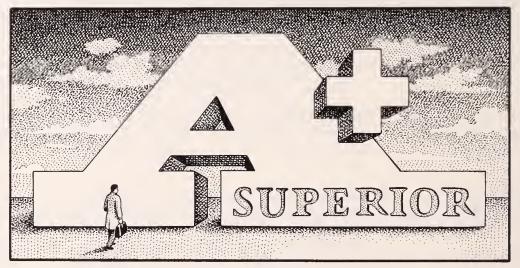
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## A Ten Year Retrospective Study Of Breast Cancer In A Rural Mississippi Setting

OCTAVIO J. CARRENO, MD RICHARD J. FIELD, III, MD, FACS RICHARD J. FIELD, JR., MD, FACS

B reast cancer is second only to lung cancer as a cause of death from cancer among women in the U.S. Much epidemiological research has been conducted with regard to this disease, but most of it has been carried out in large urban areas. This study takes a retrospective view of the epidemiology of breast cancer in a rural setting. The site of our study is Centreville, Mississippi.

Centreville is a small farming town in the south-western part of the state. Its trade area consists of approximately 25,000 people. The racial distribution is roughly 50% white, and 50% black. The institution where our study was conducted is the Field Hospital and Clinic. It is a bi-county hospital of sixty-six beds and is the only inpatient facility within a fifty mile radius.

This investigation was conducted through the retrospective analysis of all the breast cancer patients treated at the Field Clinic over the past ten years. Cases selected for the study were limited to only those whose charts were complete from the time of initial presentation, through the course of the disease.

#### **METHODS**

Our study consisted of 54 women, of which 18 were black, and 36 were white. Various epidemiological factors relevant to the study of breast cancer were investigated. These factors related to median age of initial presentation, initial signs and symptoms, pathological types, and staging at time of surgery. In addition, racial distribution with relation to age, and to initial presentation were assessed. Perhaps most importantly, patients presenting through mammography screening were compared to patients presenting with both early, and late signs of disease. This was done by comparing the postsurgical staging of these patients with regard to their form of presentation. Patient outcome was not followed, and was assumed to be the same as the 5 and 10 year survivals outlined by the TNM staging system.

The median age of presentation for our group was 64.47 years. This was almost five years older than the national average, which is 60.50 years. The median age calculated among black in our study was 58.95 years, as compared to that of

whites which was determined to be 67.71 years.

The initial signs and symptoms at the time of presentation were studied in three separate categories: (1) Patients presenting with a palpable breast mass. (2) Patients presenting with a mammogram suspicious for malignancy. (3) Patients presenting with late signs of disease (ie., skin ulceration, palpable axillary nodes, etc...). From the cases we reviewed 75.9% (41/54) of patients presented with a palpable breast mass, 20.3% (11/54) presented with suspicious mammograms, and 3.7% (2/54) pre-

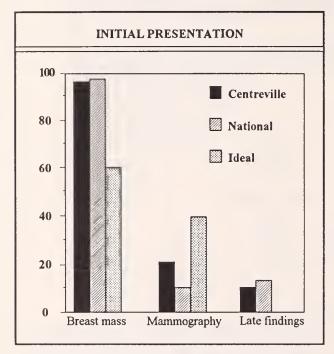


Figure 1. A comparison of initial presentations between our study, national averages, and ideal.

sented with late findings indicative of metastases (see figure 1).

Among the black patients 77.0% presented with a palpable breast mass, 11% (2/18) presented with suspicious mammograms, and 11% (2/18) presented with late manifestations of disease (see figure 2). This contrasted with the white patients which presented with a palpable breast mass 75% (27/36) of the time, but who's presentations by suspicious mammogram were much higher at 25% (9/26). In addition there were no white patients that presented with late manifestations of disease.

Staging of the disease was done individually according to the TNM staging criteria for breast cancer. Once all patients had been staged we divided them into three different groups based on their form

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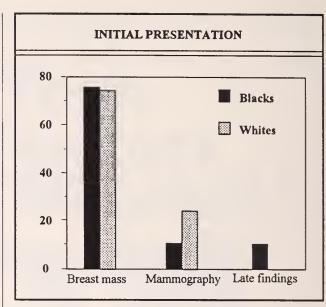


Figure 2. A comparison of initial presentations between black and white subjects in our population.

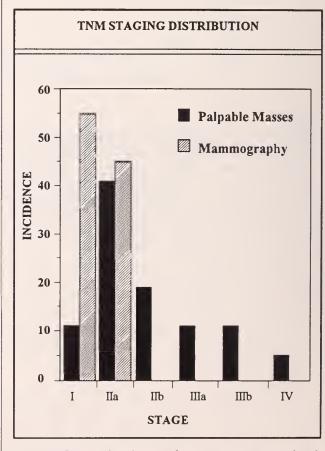


Figure 3. Staging distribution of patients presenting with palpable breast masses versus those presenting with suspicious mammograms.

of presentation. The first group consisted of only patients that presented initially with a palpable breast mass. The second group consisted of only patients that presented by suspicious mammogram. The third group consisted of patients that presented with only late findings. Here no comparisons were made with regard to race (see figure 3).

Our results were as follows: (1) The former group had an incidence of 12% (5/43) with stage I disease, 42% (18/43) with stage IIa disease, 19% (8/43) with stage IIb disease, 12% (5/43) with stage IIIa disease, and 12% (5/43) with stage IIIb disease. (2) The middle group had an incidence of 55% (6/11) of patients to have Stage I disease, and 45% (5/11) to have Stage IIa disease. (3) The latter group had an incidence of 100% (2/2) with stage IV disease. The prognosis for these patients based on the TNM staging system for breast cancer is as follows: (1) Stage I five year survival is 85%. (2) Stage IIa+b five year survival is 66%. (3) Stage IIIa+b five year survival is 41%. (4) Stage IV five year survival is 10%. Obviously early diagnosis and treatment is of utter importance. However clinical staging is of greatest prognostic use when the tumor type is known.

The last area investigated in our study was that of pathological typing of our population in comparison to that of the rest of the country. Here again racial influences were of little practical use, so no racial distributions were calculated. Our data showed that of the population of 54 women 66.7% (36/54) had infiltrating ductal pathology, 7.4% (4/ 54) had lobular invasive pathology, 22.2% (12/54) had intraductal noninvasive pathology, and 3.7% (2/54) had other rare tumors (SCCA, and cystosarcoma phylloides) (see figure 4). These values correlated well with the national averages of 70-80% for infiltrating ductal pathology, 6-8% for lobular invasive pathology, and 1% for other rare tumors. However, there was a large discrepancy between our incidence of intraductal pathology, and that of the national average which was notably lower at 4-6%.

No statistics were calculated in terms of patient long term outcome in our group for several reasons. Firstly, many patients that were several years in remission were lost to follow up. Secondly, many of the patients being followed were at different time intervals from the time of initial presentation to time of the last follow up visit. Thirdly, several patients were deceased from causes not related to their breast cancer. Fourthly, some patients that developed recurrences were transferred to the care of major cancer centers in nearby cities.

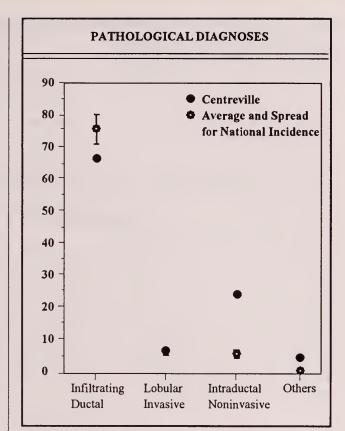


Figure 4. Comparison of national versus Centreville's incidence of pathologic types.

### **CONCLUSIONS**

The median age of onset in our population was four years greater than that of the national average, most likely the discrepancy occurred because of the relative small size of our population. The fact that the median age among whites was almost nine years higher than for blacks does correlate with the higher incidence of disease among black women. However, since the size of the population of black women in our study was so small (18), the significance of this value is questionable.

With regard to how the patients in our group initially presented, several conclusions can be made. Firstly, since only 20.3% (11/54) of patients in our group presented as a result of mammogram screening, and ideally up to 40% of breast cancers can be detected by intensive mammogram screening, there needs to be increased implementation of mammogram screening in this community (see figure 1). Secondly, since our study showed quite decisively that the patients in the mammography group went on to have significantly less severe disease in terms of staging and prognosis, this argues in favor

of increasing screening, as the cost effectiveness of such a program would be heralded by a dramatic decrease in morbidity and mortality in this community (see figure 3). Thirdly, since only 11% of the blacks in this study presented by mammography, and all of the patients in our group that presented with severe disease were black, it can be assumed that education about the significance of early intervention in breast cancer is further decreased in this population (see figure 2). This is most distressing because this group is also at the highest risk for the disease. However, these arc only relative assumptions, because the size of our population was too small to be of statistical significance.

Finally, the analysis of the incidence of various pathological types in this population showed a relatively normal distribution, with the exception that there was a markedly increased incidence in intraductal noninvasive carcinoma (see figure 4). Reasons for this occurrence are unknown. Possible explanations include an increased genetic prevalence in this area, or some predisposing environmental factor, or that it was just a chance occurrence too small to have it average out.  $\square$ 

260 Main Street Centreville, MS 39631

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Dr. Field, Jr. is a surgeon in private practice in Centerville, Mississippi. He is a Clinical Professor of Surgery, Tulane University School of Medicine, New Orleans, Louisiana; Louisiana State University School of Medicine, Baton Rouge, Louisiana; and University of Mississippi School of Medicine, Jackson, Mississippi. Dr. Field, III, is a surgeon in private practice in Centreville and an Instructor of Surgery, Tulane University School of Medicine, New Orleans, Louisiana. Dr. Carreno was a 4th year medical student at Tulane University School of Medicine when this paper was written.



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# The Confidentiality and Release of Medical Information

WILLIAM F. ROBERTS
General Counsel
Mississippi State Medical Association

(The following article was written at the request of the state legal assistants association for publication in their monthly newsletter. It is reproduced here because of its likely interest to physicians.)

A ttorneys frequently have a need to obtain medical information on behalf of their clients. In most civil tort actions, medical information is needed by both the plaintiff and defense attorneys to determine the issue of causation and/or the nature and extent of any physical and/or mental injuries. Consequently, attorneys and their legal assistants need to have a good understanding of the laws and other requirements governing access to medical information.

In Mississippi, the confidentiality of medical information and access to that information are generally governed by (1) statutory law; (2) regulations; and (3) medical ethics.

#### STATUTORY LAW

Under Mississippi law, communications between physician and patient are privileged. Section 13-1-21(1), Mississippi Code of 1972 (Annotated) provides that all communication made to a physician, osteopath, dentist, hospital, nurse, pharmacist, podiatrist, optometrist or chiropractor by a patient or by one seeking professional advice are privileged and that neither the physician or any of the other aforementioned persons or entities shall be required to disclose the information in any legal proceeding, except at the request of (1) the patient; (2) the personal representative or heirs of the patient if the latter is deceased; or (3) in the case of a contested will, by the personal representative or legal heirs of the patient, or the personal representative of the patient's legal heirs.

In addition to the three exceptions to the physician-patient privilege enumerated in Section 13-1-21(1) there are other specifically delineated exceptions contained in the Mississippi Code of 1972. One of the exceptions frequently used by attorneys to request medical information is Section 13-1-21(4) which automatically waives the privilege whenever a patient initiates any malpractice action or claim against a physician or certain other enumerated medical personnel.

Just as Mississippi law makes medical information privileged, it also imposes penalties for the violation of that confidentiality. Section 13-1-21(3) makes any willful violation of the physician patient privilege a misdemeanor. That code section also provides

that a physician or any other health care provider who has a duty to maintain the confidentiality of medical information shall also be civilly liable for damages resulting from any willful, reckless or wanton acts or omission associated with the release of such information.

With regard to civil liability for violating the physician patient privilege, a cause of action may be based on such things as invasion of privacy or breach of contract.

The release of privileged medical information is governed by Mississippi law specifying who may consent to medical and/or surgical treatment. Section 41-41-11, Mississippi Code of 1972 (Annotated) provides that, "any person authorized and empowered to consent to surgical or medical treatment or procedures for himself or another may also waive the medical privilege for himself or the other person and consent to the disclosure of medical information .... " (emphasis added). The persons who may consent to treatment and, therefore, waive the confidentiality of privileged medical information pursuant to Section 41-41-11 are:

- any adult for himself or herself
- a parent for his or her minor child or child of unsound mind (in cases of divorce, a non-custodial parent may authorize the release of information unless a court rules otherwise)
- in the absence of a parent, a maternal or paternal grandparent for their minor grandchild or grandchild of unsound mind
- a guardian, conservator or custodian for his or her ward
- an adult for his or her parent of unsound mind, mi-

- nor sibling, or sibling of unsound mind
- an emancipated minor or one who understands the nature and consequences of the release, for himself or herself
- a married person for his or her spouse of unsound mind
- any female for herself, regardless of age, in connection with childbirth or pregnancy

#### REGULATIONS

The principal regulations governing the ownership and release of medical records of physicians, osteopaths and podiatrists were promulgated by the Mississippi Board of Medical Licensure in November, 1990. The Board of Medical Licensure is the entity responsible for licensing and regulating physicians, osteopaths and podiatrists in Mississippi.

Under the Board's regulations, medical records are defined as "all records and/or documents relating to the treatment of a patient, including, but not limited to, family histories, medical histories, report of clinical findings and diagnosis, laboratory test results, X-rays, reports of examination and/or evaluation and any hospital admission/discharge records which the physician may have".

The regulations specifically recognize that medical records are the property of the physician or physicians in whose clinic or facility the records are maintained. Accordingly, the regulations are consistent with generally recognized legal principle that medical records are the property of and are owned by the physician, not the patient.

Even though the Board's regulations recognize ownership of the records by the physician, a specific right of reasonable access to the information in the record is accorded the patient. The Board of Medical Licensure requires that a physician, upon request of the patient or the patient's legal representative, provide either a summary or copy of that person's medical record to the patient or his/her legal representative. The regulations define "legal representative" as "an attorney, guardian, custodian, or in the case of a deceased patient, the executor/administrator of the estate, surviving spouse, heirs and/or devisees".

The regulations afford a physician two methods of complying with the requirement of permitting access to a medical record when requested by the patient or his/her legal representative: (1) the physician may provide the patient with a photocopy of the record, or; (2) a narrative summary of the information in the record may be provided. If the physician elects to provide the patient with a copy of the record, then payment of any costs associated with duplicating the record, not to exceed one dollar per page, may be required in advance. If a written, narrative summary of the record is provided, the regulations do not prohibit the physician from imposing a reasonable charge for his or her professional time in preparing the summary.

Two additional stipulations are included in the Board's regulations governing the release of and access to medical records. First, the physician has a right to request and obtain a written authorization from the patient prior to release of the record. Second, a physician cannot refuse to honor a request for release of the medical record on account of an unpaid bill for medical services.

Violation of these regulations by a physician are grounds for disciplinary action by the Board under its rather broad grant of

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authority to impose such action for unprofessional, dishonorable or unethical conduct pursuant to Section 73-25-29(8), Mississippi Code of 1972.

### ETHICAL CONSIDERATIONS

Long before the adoption of statutes and regulations addressing the confidentiality of medical information, physicians have been guided in such areas by the Principles of Medical Ethics. The Principles are based on the Oath of Hippocrates and were first adopted by the American Medical Association (AMA) in 1847.

Principle IV states that, "a physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of

the law". Similarly, paragraph 5.05 of "Current Opinions" of the AMA Council on Ethical and Judicial Affairs provides that,

"The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient. unless required to do so by law."

Another important set of guide-

lines covering the release of confidential medical information is found in the "Professional Guide for Attorneys and Physicians". The Guide was developed many years ago by The Mississippi Bar and the Mississippi State Medical Association to establish a standard of conduct between physicians and attorneys. It was recently updated in 1992.

Section 3(b) and (c) in Article I of the Guide covers the proper method of requesting medical information by attorneys and contains the suggested information which should be included in both the request for the medical report and the report itself. The Guide also contains a suggested form for use in obtaining a patient's written authorization to release medical information.



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The President's Page MALLAN G. MORGAN, MD

## The Image

"Poor, dismal, ugly, sterile, shabby little man... with your scrabble of harsh oaths... joy, glory and magnificence were here for you... but you scrabbled along... rattling a few stale words... and would have none of them."--- Thomas Clayton Wolfe

Several weeks ago (or several months by the time this is published), someone who purported to be a "Jackson Surgeon" wrote a reply to an editorial by Clarion-Ledger columnist, Orly Hood. Mr. Hood had complained about waiting in a surgeon's office for over an hour and a half without explanation or apology. On closing his column, Mr. Hood's reply to this surgeon was, "You're Fired!". The letter by the person calling himself a "Jackson Surgeon" in response to that column was arrogant, condescending and totally out of place.

The image of physicians in this country has deteriorated. We used to be the most honored profession, but we have now dropped to number three or four. Part of this slippage comes from the portrayal of physicians in the mass media as money hungry, uncaring, distant individuals who have lost their rapport with their patients. Or as in some T.V., movie and novel plots, the physician is portrayed as a thief, a murderer, or worse. Maybe the new T.V. show, "Diagnosis Murder" will help since, for a change, the doctor is a "Good Guy". I realize that most patients respect and some even revere their own doctor, but many are now influenced by the media to distrust all physicians.

Comments like those from the "Jackson Surgeon" certainly don't help. This attitude just fuels the fire of distrust and disdain that is growing between patients and their physicians. I also think that if the person who wrote the letter, if it was a

(Continued on page 264)

## **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 9 SEPTEMBER 1994

## Listen and Then Look

Recently I was asked to review several complaints made by patients against physicians. A major lapse in communication between the doctor and the patient was the primary problem cited in each complaint. These findings stimulated a review of doctor-patient communications, and I was surprised to find such problems are very common in these relationships. A very specific area of concern was that in many malpractice cases the plaintiff pursued the action because, "the doctor would not talk to me about my problem".

Because of these findings, I conducted an informal survey for several months, asking patients, "what is the single most important thing you would like for your physician to do while managing your medical problems?" Although a variety of responses were obtained sixty-five percent of those surveyed wanted the doctor "to talk to and listen to" them. I was very surprised and concerned to hear such expressions from my patients as I have always been very conscious of the need for good doctor-patient communications, and thought I had done well in meeting these needs. To determine if my experiences were usual I enlisted the help of several colleagues, each of whom conducted a similar informal survey with essentially the same results.

The essence of any relationship is proper communication between the parties involved, be it doctor-patient relationship, or other professional and personal relationships. The basic purpose of communications is to convey thoughts, desires and feelings. In the case of the doctor-patient relationship communication is necessary to convey professional guidance, instructions and care. An essential component of this relationship is to provide the patient an opportunity to convey their problems to the physician. A dialog must be established in order for the physician to know and understand the problems and desires of any patient. This requires one to be fully conscious of the total patient: age, educational background, and emotional, physical, family and financial problems. All of these issues weigh heavily on individuals and significantly influence how they listen to, and talk to, their doctor. In one situation I thought I had done a great job informing the patient about a problem only to find that the patient was so concerned about the possibility of cancer that nothing I said had been heard. The patient later even denied that it had been said at all.

Practicing good communicative skills in medicine is difficult. The wide variety of personalities confronted, varying stages of illnesses, different social backgrounds, multinational populations, the variety of settings in which care is rendered, and a wide range of patient expectations, make the task difficult, but not impossible. The single most im-

(Continued on page 264)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

physician, had taken a moment to think and cool off a little, that letter would never have been mailed. I also think that he/she is now embarrassed since he/she has not come forward to admit authorship.

After a few more comments, we will let, I hope, sleeping dogs lie. I would like to remind us all that we are the champions of the physicians' image. It is what we do, what we say, and how we act with our patients that determines the image that those patients have of doctors.

We all know of the civic activities of many of our colleagues, the "pro bono" or uncompensated care we give, the long hours, the unexpected emergencies, etc. that is part of the practice of medicine. But the patients don't know. So, as a reminder, in order for us to try to restore the image of our profession that it deserves, have someone on your staff tell your patients when you have been delayed and why. Have your staff give the patient the option of waiting or rescheduling. Be considerate, It can only help your image and improve your practice.

I am reminded of a President's Page last year written by Dr. Don Q. Mitchell, when he talked about his friend-WALT.

W - Walk like a physician.

A - Act like a physician.

L - Look like a physician.

T - Talk like a physician.

If we could do this, and include consideration for our patients, our image could only improve. By the way, I found my book of quotations:

> "O wad some power the giftie gie us to see oursel's as others see us." ---Robert Burns (1759-1796)

> > Mal

P.S.— Thanks to the MSMA Report for publishing Dr. Vann Craig's Speaker of the House comments on Unity and to Vann for what he said to the MSMA House of Delegates in May. Thanks also to Dr. Dwalia South for her editorial on Unity in the July Journal MSMA.

portant ingredient in structuring a good relationship is a genuine concern for the patient. Without this it is difficult to generate the time and energy required to establish a good relationship.

One might ask, "why is it necessary to make an effort to establish a good doctor-patient relationship?" Primarily, that is exactly what the patient is paying for; total care of the specific problem requiring the examination and treatment. Even more important it is the courteous and proper thing to do in any relationship. It may also help keep you out of the courthouse. With the rapid changes occurring in medicine today it may also help retain your practice, as patients no longer have to tolerate such abuses.

Remember: Listen first and then look.

Myron W. Lockey, MD

Editor





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## Editor Journal of the Mississippi State Medical Association

Dear Sir:

Having read Dr. Cannon's interesting original article, "Fine Needle Aspiration (FNA) of Parotid Masses," I am writing to give "another opinion."

The histologic diagnosis of salivary tumors is a notoriously difficult area of pathology, and therefore many head and neck surgeons are hesitant to predicate any important decisions in parotid surgery (i. e., whether to sacrifice the facial nerve or its branches) upon either frozen section histopathology or needle biopsy results. Salivary tumors often have variable histologic appearances in different areas of the tumor, and the pathologist deserves to have a generous specimen, preferably the entire tumor, for processing and microscopic examination. Dr. Cannon correctly mentions reports of other series in which the diagnostic accuracy of needle biopsy was as low as 50 percent.

Second, while an experienced head and neck surgeon, with a knowledge of the normal anatomy of the facial nerve, could expect a low probability of facial nerve injury with a carefully directed aspiration biopsy, the risk of an injury to the facial nerve or its branches with this procedure is very real. Facial nerve anatomy is not constant, and tumors in the parotid gland can distort "normal" anatomy of this nerve and its branches, so that, even in experienced hands, the procedure of a needle biopsy of a parotid tumor does expose the patient to the risk of facial nerve injury, and this procedure should be considered a very hazardous undertaking by a physician inexperienced with facial nerve anatomy.

Third, a superficial parotidectomy, the standard operation to remove probably 90 percent of parotid tumors, entails very low morbidity and, in experienced hands, a very low risk of facial nerve injury. When the tumor is benign, certainly every effort should be made to maintain the integrity of the facial nerve and its branches as the tumor is removed, and, in the vast majority of malignant tumors, the facial nerve should be and can be preserved intact, in nearly every case consistent with complete extirpation of the tumor. Certainly there are exceptions to the foregoing statement regarding malignant tumors, but, as a general rule, this is correct.

Another point is that Dr. Cannon did not advocate not removing benign parotid tumors, and I believe that this is consistent with the feeling of most physicians experienced in this area of surgery. The clinical distinction between a neoplasm and an inflammatory process of the parotid gland rarely is difficult. Therefore, though a needle biopsy is a relatively inexpensive step, it also is an unnecessary one. The estimated hospital charge (\$8,700) for a parotidectomy cited by Cannon seemed high to me. In this community, parotidectomies normally are undertaken on an outpatient basis under general anesthesia, and the average hospital charge for our most recent five parotidectomies this year has been \$3,450.

In summary, I maintain that a fine needle biopsy of a parotid tumor is an unnecessary procedure at best; it entails some degree of risk; and, at worst, it can be misleading if one regularly were to base any important decisions upon this diagnostic procedure.

Yours truly,

Unitary & Gality my

Michael H. Carter, Jr., M. D. Greenwood August 5, 1994

(Letters continued on page 266)

LETTERS, COMMENTS or QUERIES.... The Editors of *Journal MSMA* invite members of the MSMA to comment for publication on any material that appears in the publication or on other current medical issues. If you have a letter, comment or query, please send it to: The Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

## A TRIBUTE TO DR. JESSE THEO DAVIS

On July 5, 1994, Mississippi lost a great leader with the passing of Dr. J. T. (Jake) Davis. Corinth and Northeastern Mississippi lost a fine surgeon and pillar of their community. His family lost a loving, supportive husband, father and grandfather. Many of us lost an exceptional and inspiring friend.

As a young boy, Dr. Davis grew up working hard on a farm. Loving parents and several brothers and sisters instilled a strong sense of values, self-sufficiency, and service to others. With an indomitable spirit, Dr. Davis treated life as an opportunity and an adventure. He strove to develop his talents to the fullest, and, with kindness and concern, he shared these talents and their fruits with family, friends, neighbors, patients, and colleagues. He practiced general surgery for 58 years. Over these years, he held many responsible positions in the Mississippi State Medical Association including the Presidency. He had a substantial influence on the availability and delivery of quality medical care to all Mississippians. Right up until the end, he remained a vibrant, sharp, 89 year old youngster with a twinkle in his eye, a quick smile, and as sharp a mind as one would ever want to see.

As a surgeon, Dr. Davis loved hand and upper extremity problems. His interest was spawned and stimulated by his service in the European Theater of World War II, a war which birthed hand surgery as a specialty. Dr. Davis

became a self-educated and very excellent hand surgeon. Four years ago, with a vision to the future, he generously endowed the J. T. Davis Visiting Lectureship in Hand Surgery. His goals were to provide continuing education for outlying physicians, especially general surgeons in the State of Mississippi who unavoidably become primary care physicians for patients with problems of the hand and upper extremity. In addition, the Lectureship embraces the education of aspiring hand and upper extremity surgeons at the University of Mississippi Medical Center.

It was a true joy to work with Dr. Davis. We will miss him immensely. Dr. J. T. Davis was truly Mississippi's pioneer hand surgeon. Following his directive, we will continue his work, advancing his high values and standards. In doing so, we will be educating those people who will one day be his and our successors.

Sincerely,

Alan E. Freeland MD

Michael Jabaley

Michael E Johnson MD

James L. Hughes, MD

Suman K. Das, MD Jackson August 17, 1994 To The Editors
Journal MSMA

Editors:

Extra! Extra! Read all about it....hopefully before your patient's attorney does.

The words of the rather inconspicuous newspaper article sent chills down my spine... "patient deaths...a type of anemia...new seizure medication..."

The item went on to say disconcertingly that physicians had been notified of this problem by the pharmaceutical manufacturer and that the medication was being recalled.

The frantic whirring of office fax machines on the next day followed by the receipt of contradictory glow-in-the-dark communications served only to underscore the dilemma of physicians who had placed patients on the doomed drug.

A wedge of doubt regarding the responsibility of the pharmaceutical industry to the practicing physician was further introduced by recent notification of changes in indications for a drug following prime-time television revelations of alleged devastating adverse reactions.

As physicians, we realize that unfavorable outcomes do occur, however, just as we have been advised to be "up front" with our patients in such instances, it seems to me reasonable that we should learn of potential problems from representatives of the pharmaceutical industry rather than through the tabloid-talk show format.

Sincerely,

Stanley Hartness, M.D.

Stanley Hartness, MD

Kosciusko

August 28,1994

## COMMENTS

Editor's Note:

There have been several newspaper articles in the last few weeks concerning Physician Assistants. Printed here for your information is the Association's position adopted by the MSMA House of Delegates in 1981.

Registration of Physician's Assistants and other Allied Health Professionals; Background; Based on an increasing amount of support in the Mississippi Legislature for licensure, certification or registration of allied health professionals in this state who are not presently licensed, the Council on Legislation requested the Board of Trustees to appoint a special committee to study this question. The Board of Trustees appointed the Council on Legislation as the special committee and requested that the Council present a report and recommendations to the Board and House of Delegates. The Council reviewed licensure laws for allied health professionals in several other southern states as well as the AMA's latest position paper on physician's assistants. Based on their study, the Council recommends adoption of the following as the association's position on allied health professionals.

- 1. Physician's assistants are not necessary in every practice setting, but in certain situations, they may be useful and desirable in rendering health care.
- 2. The Association does not support the education and training of additional physician's assistants, and particularly opposes the use of federal funds for such training.
- 3. The Association does recognize that physician's assistants and other allied health professionals are presently functioning in this state without licensure, certification or registration, and thus, some mechanism is needed to insure that such persons are properly qualified to function and that they are in fact rendering quality patient care.

Based on these positions, the Council on Legislation recommends that the Association not oppose legislation to provide for registration of physician's assistants and other allied health professionals provided the following criteria are met;

- A. That no new board would be constituted to provide such registration and that such registration would be a function of the Board of Medical Licensure.
- B. The Board of Medical Licensure must be satisfied that the person applying for registration has met educational and training requirements as set by the certifying body which certifies such allied health professional as a minimal requirement for registration.
- C. That a specific physician or physicians duly licensed to practice and in fact practicing in the State of Mississippi must assume complete supervision and total responsibility for the acts of such allied health professional.
- D. Any law should include specific fines and penalties for practice outside the scope of registration.
- E. The Board of Medical Licensure should be given authority to set rules and regulations and if necessary or desirable, additional educational requirements governing the practice of such allied health professionals.

Report of the Reference Committee on Reports of Officers, Board of Trustees and Councils.

This report sets forth policy statements of the association regarding physician's assistants and other allied health professionals. It also recommends that the association not oppose legislation to register allied health professionals provided that the legislature gives full and complete authority to the Board of Medical Licensure for such registration. It should be specifically pointed out that this report does not call for licensure of allied health professionals. Your reference committee believes that the recommendations in this report are well thought out and would like to commend the Council on Legislation for its research in preparing this report.

The report of the reference committee was adopted.



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## **Medical Organization**

## Singing River Medical Society Conducts Second Set of Mini-Internships

A second group of businessmen and elected officials recently got an "inside view" of the health care delivery system in Jackson County.

Physicians of the Singing River Medical Society invited eight individuals to take part in a two-day "mini-internship," July 25-26, during which participants made rounds with doctors, observed surgical procedures spent time in the Singing River Hospital Emergency and Radiology Departments and followed the participating physicians through half a day of office visits. The first such program was held April 18-19.

"Our mini-internship program is an effort to establish ongoing and open communications with key members of the community," said Dr. Richard Whitlock, Family Practitioner, who is a member of the SRH Medical Staff and President of the Medical Society. "This program shares the humane concerns of physicians and health care providers through first-hand experience with the selected interns."

Interns were chosen and invited by the Medical Society based on their positions as decision-

makers in industry and government. Those "interns" participating in the program were the following: Michael Bagwell, Singing River Board of Trustees; Terry Carter, Jackson County Area Chamber of Commerce; Carroll Clifford, III, Jackson County Board of Supervisors; Wanda Jacobs, Publisher, Mississippi Press; J. S. "Sid" King, SRHS Board of Trustees; Steve Pierce, Insurance Administrator, Ingalls; and W. Lee Watt, Attorney, Brown & Watt, P.A.

# Dr. Norman C. Nelson Retires After More Than Twenty Years of Service

After standing in a reception line at UMC to shake hands with more than 6,000 well wishers, Vice Chancellor for Health Affairs and Dean, School of Medicine Dr. Norman C. Nelson, retired on Friday, July 29.

Dr. Nelson, who came to UMC after many years as a professor at Louisiana State University Medical School, drew praise from UMC colleagues and state higher education leaders alike for guiding the medical school through its successes.

He came to the Medical Cen-

ter in July, 1973, as vice chancellor for health affairs, dean of the School of Medicine and professor of surgery. He was the Medical Center's fifth CEO at a time when the institution was poised for growth but needed a boost. Dr. Nelson proved to be the catalysts the 18-year old center needed. His 21-year tenure has been marked by continuous, rapid growth in all areas.

UMC's student body grew from 1,100 in 1973 to 1,731 today. Dr. Nelson directed nine major building programs, including the den-

tal school.

Dr. Nelson's administrative skills were recognized in 1985 by the Mississippi Chapter of the American Society for Public Administration which gave him its first Herman Glazier Award—the highest honor a public administrator can receive.

Dr. Nelson leaves the Medical Center with more than bricks and mortar. He leaves it with a legacy of excellence, poised on a strong foundation and equipped to meet the challenges of a new century.



Many friends wished Dr. Nelson well at his retirement dinner

# Two Decades of Accomplishments

Student	1098	1731
Patients	134,651	267,998
Employee	2906	5200
Research, Sponsored		
<b>Programs &amp; Contracts</b>	\$6 million	\$19.1 million
Endowments	\$117,989	\$ 14.3 million
Budget	\$32.8 million	\$209.9 million

## The Nelson Years: Two Decades of Excellence



Jan Evers and MSMA President, Mal Morgan, MD were among those congratulating Dr. Nelson.

#### **Educational Programs**

New baccalaureate curricula in clinical laboratory sciences, cytotechnology, dental hygiene, health information management, occupational therapy and respiratory care; new certificate programs in emergency medical technology, radiation therapy and advanced diagnostic imaging

1973 — 1994

New residencies in emergency medicine, general practice dentistry and advanced education in general dentistry Admission of two classes annually to the baccalaureate nursing program; new nurse clinician training programs in adult and gerontological nursing for nurses with master's degrees; new curriculum patterns for RNs to earn baccalaureate and master's degrees

### 

School of Dentistry
Lecture Hall Addition
Resource Center
Clinic
James D. Hardy Clinical
Sciences Building
University Medical Pavilion
Research Building
Research Building
Research Building
Research Building

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Student UnionUniversity Medical Pavilion AdditionSchool of Health RelatedPerinatal CenterDiagnostic Radiology BuildingProfessions BuildingBlair E. Batson Hospital for ChildrenNew Medical Intensive Care UnitTwo Parking Garages

Renovation Projects Underway ......\$18.2 million

## Over 120 Attend MSMA Annual Medical Student Pizza Luncheon

Each year the MSMA sponsors a pizza luncheon for 1st year UMC medical students to introduce them to the MSMA and the AMA. Don Q. Mitchell, MD, MSMA immediate past president was guest speaker. Dr. Mitchell talked about the importance of physicians being part of organized medicine and the role of the AMA Medical Student Section.





Mark Strong, at left, a third year student, recruited students for AMA Student Section membership. Below, UMC Associate Dean for Academic Affairs Dr. Helen Turner, attended the luncheon and visited with Dr. Mitchell and students.



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## The University of Mississippi Medical Center



# Robertson Named Associate Vice Chancellor

Dr. Roland B. Robertson, director of the Division of Continuing Health Professional Education and associate professor of medicine, has been named associate vice chancellor for health affairs at the University of Mississippi Medical Center.

Dr. Wallace A. Conerly, vice chancellor for health affairs, announced his appointment following approval by the Board of Trustees at their August meeting.

Dr. Robertson earned the BS at the University of Southern Mississippi and the MD at the University of Tennessee Medical School. He took his internship at John Gaston Hospital City of Memphis Hospital and completed his residency in internal medi-

cine at UMC. He was assistant vice chancellor for VA Affairs and chief of staff at the VA.

Dr. Robertson also has served in various capacities in the military including captain of the Medical Corps in the U.S. Air Force and flight surgeon at Shaw Air Force Base in South Carolina form 1961-63, and colonel, flight surgeon, in the Mississippi Air National Guard from 1979-1989. He is currently active in the Mississippi Air National Guard as state sir surgeon.

His professional memberships include the Association of Military Surgeons, American College of Physicians, American College of Chest Physicians, American Thoracic Society and the Mississippi Thoracic Society.

Dr. Robertson, a native of Taylorsville, is married to Jane McKelvey Robertson.□

# Christ Selected AAN Fellow

Dr. Mary Ann Christ, dean of the School of Nursing at the University of Mississippi Medical Center, has been selected as a fellow of the American Academy of Nursing. Acknowledged because of her contributions and achievements in nursing, Dr. Christ will attend an induction ceremony for new fellows at the academy's annual meeting and conference in October in Phoenix, Arizona.

A native of Binghamton, N. Y., Dr. Christ earned the AAS in 1969 at Adirondact Community College at Glen Falls, the AA in 1972 at the Community College of Finger Lakes at Canadaigua, the BSN in 1973, the MS in 1975, and the EdD in 1981 at the University of Rochester. She also took postgraduate training in primary care as a Robert Wood Johnson Faculty Fellow in 1981 at the University of Colorado in Denver and received the American Nurses Association certification as a gerontological nurse practitioner in 1986.

# Cruse and Lewis Author Dictionary

The Illustrated Dictionary of Immunology, authored by Dr. Julius M. Cruse and Dr. Robert E. Lewis, Jr., professors of pathology at the University of Mississippi Medical Center, will be published in December by CRC Press, Inc., in Boca Raton, Florida.

Written for students and clinicians as well as scientists, the dictionary features a thorough treatment of contemporary immunological definitions, 650 illustrations that clarify and demystify immunological concepts, and an appendix of the latest cluster of differentiation designations on leukocyte surface markers.

This is the first illustrated immunology dictionary ever published that is encyclopedic in scope, covering both basic medical science and clinical aspects of a subject that intersects essentially all spheres of medicine.

JOURNAL MSMA

## **New Members**

ALMAS, JAMES P., Jackson. Born Montana, December 24, 1949; MD, Columbia University College of Physicians and Surgeons, New York, NY, 1976; interned and pathology residency, Los Angeles County University of South California Medical Center, Los Angeles, CA, 1976-80; elected by Central Medical Society.

ARMSTRONG, WILLIAM D., Greenwood. Born Columbia, MS, January 12, 1959; DO, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1987; interned one year, Charles E. Still Osteopathic Hospital, Jefferson City, MO; internal medicine residency, University of South Alabama Medical Center, Mobile, AL, 1988-90; elected by Delta Medical Society.

BELLARE, NAGENDRANATH, Hattiesburg. Born Bangalor, India, June 29, 1944; MD, Bangalore Medical College of Medicine, India 1965; interned one year, Victoria Hospital, Bangalore, India; medicine residency, Cook County Hospital, Chicago, IL, and Northwestern University School of Medicine, Chicago, IL, 1967-70; hematology/oncology fellowship, Cook County Hospital, Chicago, IL, 1970-71; elected by South Mississippi Medical Society.

BOOS, DONALD L., Meridian. Born Denver, CO, October 8, 1955; MD, Medical College of Ohio at Toledo, Toledo, OH, 1985; interned one year, St Luke's Hospital; anesthesiology residency, Univ. of Virginia, Charlottesville, VA, 1986-89; elected by East Mississippi Medical Society.

**BRADFORD, ROGER M.**, D'Iberville. Born Evansville, IN, March 24, 1944; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; family practice residency, same, 1986-89; elected by Coast Counties Medical Society.

BRAND, WOODROW W., III, Amory. Born Houston, MS, January 28, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; general surgery residency, University Medical Center, Jackson, MS, 1988-93; elected by Northeast Mississippi Medical Society.

BRIDGES, ERIC W., Meridian. Born Cedar Falls, IA, July 7,1961; MD, Louisiana State University School of Medicine, New Orleans, LA, 1989; general surgery internship, University of Texas Medical Branch, Galveston, TX, 1989-90; otolaryngology residency, same, 1990-94; elected by East Mississippi Medical Society.

DIX, R. BRIAN, Gulfport. Born Indianapolis, IN, June 30, 1959; DO, West Virginia School of Osteopathic Medicine, Lewisville, WV, 1990; one year internship, Indianapolis, IN; anesthesiology residency with training in chronic pain & cardiovascular anesthesia, Indiana University School of Medicine, Indianapolis, IN, 1991-94; elected by Coast Counties Medical Society.

GARCIA, MARY ANN, Corinth. Born Manila, Philippines, August 6, 1963; MD, University of Santo Tomas Medical School, Manila, Philippines, 1987; pediatric residency, University of Illinois Hospital, Chicago, IL 1989-93; elected by Northeast Mississippi Medical Society.

GEORGE, LAWRENCE M., Greenville. Born San Francisco, CA, January 15, 1954; MD, University of Kansas School of Medicine, Kansas City, KS, 1980; general surgery residency, Wilford Hall, USAF Medical Center, San Antonio, TX, 1980-85; pediatric surgery residency, LeBonheur Children's Medical Center, Memphis, TN, 1985-87; elected by Delta Medical Society.

GOBER, GREGG A., Greenville. Born Monroe, LA, January 16, 1963; MD, University of Arkansas School of Medicine, Little Rock, AR, 1989; interned one year, Georgetown University Medical Center, Washington, DC; orthopedic surgery residency, same, 1990-94; elected by Delta Medical Society.

GRAHAM, CECIL C., Gulfport. Born September 30, 1934; MD, Louisiana State University School of Medicine, New Orleans, LA, 1964; anesthesiology residency, Charity Hospital, New Orleans, LA, 1965-67 and University of Virginia Hospital, Charlottesville, VA, 1967-68; elected by Coast Counties Medical Society.

### New Members / continued

GUIDRY, SCOTT P., Hattiesburg. Born Lafayette, LA, June 27, 1963; MD, Louisiana State University School of Medicine, New Orleans, LA, 1989; general surgery residency, University Medical Center, Jackson, MS, 1989-94; elected by South Mississippi Medical Society.

**HEATH, ROBERT F.**, Petal. Born Toronto, Canada, April 27, 1950; MD, University of Toronto Medical School, Toronto, Canada, 1976; family practice residency, University of Western Ontario, St. Joseph's Hospital, London, Ontario, Canada, 1977-79; elected by South Mississippi Medical Society.

HULL, JOHN E., Pascagoula. Born New Orleans, LA, January 23, 1939; MD, Louisiana State Uni-

versity School of Medicine, New Orleans, LA, 1965; internal medicine residency, Charity Hospital New Orleans, LA, 1969-72; rheumatology residency, Louisiana State University Medical Center, New Orleans, LA, 1972-74; elected by Singing River Medical Society.

KOWALEWSKI, DONALD C., Greenwood. Born New Jersey, October 23, 1959; DO, Michigan State University of Osteopathic Medicine, E. Lansing, MI, 1987; internal medicine residency, Pontiac Osteopathic Hospital, Pontiac, MI; critical care fellowship, Wayne State University Medical Center, Detroit, MI; elected by Delta Medical Society.

KUM-NJI, PHILIP, Clarksdale. Born Weh (Cameroon), March 3, 1950; MD, University of Yaounde, Cameroon, 1977; pediatric residency, University of Tennessee College of Medicine, Memphis, TN, 1991-94; elected by Clarksdale & Six Counties Medical Society.



MALLETT, TARA S., Lucedale. Born Lucedale, MS, April 28, 1963; DO, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1989; pediatric residency University of Texas Medical Branch, Galveston, TX, 1989-93; elected by South Mississippi Medical Society.

MAGNUSSEN, CHARLOTTE, West Point. Born Montreal, Canada. January 25, 1953; MD, University of Alberta Medical School, Edmonton, Canada, 1983; ob-gyn residency, same, 1984-88; elected by Prairie Medical Society.

MILLER, C. JASON, Jackson. Born Hattiesburg, MS, October 9, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1988; pediatric residency, University Medical Center, Jackson, MS, 1988-91; neonatology fellowship, Vanderbilt Hospital, Nashville, TN, 1991-94; elected by Central Medical Society.

MUSIAL, BONITA C., Monticello. Born Canada, July 10, 1946; MD, Dalhousie University Medical School, Halifax, NS, Canada, 1983; one year internship, same; elected by South Central Medical Society.

PATEL, HARILAL R., Lucedale. Born Fiji Island, May 22, 1953; MD, University of Bombay Medical School, Bombay, India, 1980; internal medicine residency, Hurley Medical Center, Flint, MI, 1988-91; elected by South Mississippi Medical Society.

PITTMAN, TRACY B., Pascagoula. Born Meridian, MS, September 3, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; interned and medicine residency, University of Chattanooga Medical Center, Chattanooga, TN, 1989-92; nephrology fellowship, University of Florida Medical Center, Gainesville, FL, 1992-94; elected by Singing River Medical Society.

PURSER, THOMAS, III, Picayune. Born Birmingham, AL, August 13, 1936; MD, University of Mississippi School of Medicine, Jackson, MS, 1962; orthopaedic surgery residency, University Medical Center, Jackson, MS, 1963-67; elected by Pearl River Medical Society.

RICHARDSON, J DAVID, Jackson. Born Hazlehurst, MS, September 14, 1955; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; psychiatry residency, Baylor College of Medicine, Houston, TX, 1986-90; elected by Central Medi-

cal Society.

ROMINE, DAVID C., Sumner. Born West Virginia, January 13, 1961; DO, West Virginia School of Osteopathic Medicine, Lewisville, WV, 1992; one year rotating internship, Logan General Hospital, Logan WV; elected by Clarksdale & Six Counties Medical Society.

SCOTT, SETH A., Lucedale. Born Lucedale, MS, December 6, 1965; MD, University of Mississippi School of Medicine, Jackson, MS, 1984; family practice residency, University of South Alabama, Mobile, AL, 1991-94; elected by South Mississippi Medical Society.

SPRIGGS, LECIA E., Jackson. Born December 15, 1962; MD, Michigan State University College of Human Medicine, East Lansing, MI, 1989; interned one year, Mayo Graduate School of Medicine, Rochester, MN; anesthesiology residency, same, 1990-93; fellowship/obstetric anesthesiology, same, 1993-94; elected by Central Medical Society.

TUBB, TONI H., Jackson. Born Meridian, MS, July 6, 1956; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; one year internship, same; emergency medicine residency, same, 1990-93; elected by Central Medical Society.

WAIT, GERALD M., Oxford. Born Washington, DC, May 26, 1954; MD, University of Texas Southwestern Medical School, Dallas, TX,1987; general surgery residency, University of Arkansas Medical Center, Little Rock, AR, 1987-91; fellowship in cardiothoracic surgery, University Medical Center, Jackson, MS, 1991-94; elected by North Mississippi Medical Society.

WARNOCK, JAMES L., JR., Meridian. Born Montgomery, AL, February 2, 1966; MD, University of Mississippi School of Medicine, Jackson, MS, 1992; one year internship, Bethesda Naval Medical Center, Bethesda, MD; elected by East Mississippi Medical Society.

WESBERRY, JESSE M., JR, Columbus. Born Columbia, SC, August 5, 1953; MD, University of Tennessee College of Medicine, Memphis, TN, 1980; interned one year, Methodist Hospital, Memphis, TN; ophthalmology residency, Case Western Reserve, St. Lukes, Cleveland, OH, 1982-85; fellowship in Vitreoretinal Disease, Memphis, TN; elected by Prairie Medical Society.  $\square$ 

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CHARLES L. SECREST, M.D.

Dr. Secrest received his B.A. degree from the University of Mississippi, and earned his medical degree from the University of Mississippi School of Medicine. He completed his internship and residency in General Surgery at Baylor University Medical Center in Dallas, Texas; served a residency in Urology at the University Medical Center in Jackson, Mississippi; and a fellowship in Adult and Pediatric Reconstructive Urology at Eastern Virginia graduate school of Medicine in Norfolk, Virginia.



JAMES E. KEETON, M.D.

Dr. Keeton received his B.A. degree from the University of Mississippi and his medical degree from the University of Mississippi School of Medicine. He completed his internship and urology residency at University Medical Center, in Jackson, Mississippi. Dr. Keeton served a fellowship in Pediatric Urology (Senior Registrar) at the Hospital for Sick Children in London, England; and a fellowship in Urology (Clinical Assistant) at the Middlesex Hospital in London.

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## **Personals**

Joseph R. Acosta, has associated with Jeff Anderson Regional Medical Center of the practice of Obstetrics and Gynecology, 1523 22nd Avenue, Meridian.

Emily R. Baillio has associated with Jackson Medical Associates, P.A. in the practice of Internal Medicine, 1600 North State Street, Jackson.

Charles Daniel Borum of Natchez has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

Scott T. Bradley has associated with William M. Gillespie, Columbus Eye Clinic & Refractive Surgery Clinic, 425 Hospital Drive, Columbus.

Scott G. Burks has associated with The Pediatric Clinic, P.A. in the practice of Pediatrics, 1101 South 28th Avenue, Hattiesburg.

Jonathan C. Campbell, III, announces the opening of his practice if Family Medicine, 451 New Richton Road, Petal.

Jeffrey D. Crout has associated with the Children's Medical Group, P.A. for the practice of Pediatrics, 800 Carlisle, Jackson.

C. Ralph Daniel, III, of Jackson is the Mississippi State Chairman for the Dermatology Foundation's 1994 Leaders Society Campaign.

Jeffrey N. Evans has associated with J. Keith Mansel for the practice of Pulmonary Diseases and Sleep Disorders, 1203 Belk Blvd, Suite 100, Oxford.

Richard J. Field, Jr., of Centreville gave the Commencement Address for the Tulane University School of Medicine Graduating Class of 1994 at McAllister Auditorium at Tulane on June 4, 1994. Dr. Field is Director of the Field Clinic in Centreville and 2nd Vice President Elect of the American College of Surgeons.

**David Fieselman**, who has served as Director of laboratories at St. Dominic-Jackson Memorial Hospital for almost 20 years, retired on June 30.

Mark H. Fletcher has associated with Tupelo Neurology Clinic, P.A. for the practice of Neurology, 609 Brunson Drive, Tupelo.

Keith Goodfellow has associated with Dimitri Yanez for the practice of Obstetrics and Gynecology with the Hancock Women's Center, 290 Hancock Square, Suite B, Bay St. Louis. Joeseph E. Johnson, a family physician in Mt. Olive, has been appointed by Governor Kirk Fordice to the State Board of Medical Licensure.

Dewey H. Lane of Pascagoula has been appointed to the rank of assistant clinical professor in the Tulane University School of Medicine Department of Surgery. He will continue his full time practice of surgery in addition to this part-time clinical appointment.

Tracy B. Pittman has associated with Joel R. Brunt and Jack F. Glover of Gulf Coast Nephrology providing consultative services in Nephrology, Hypertension, and internal Medicine.

Seshadri Raju announces the relocation of his practice in Vascular Surgery with special interest in diseases of the venous system to 1020 River Oaks, Suite 420, Jackson.

Richard E. Rhoden, a Jackson psychiatrist, was elected chairman of the state Board of Mental Health. He has served on the Board since 1988.

Deborah Shirley has associated with R. Ray Lyle for the practice of Pediatrics, 102 Doctors Park, Starkville.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage you to send notices to: Personals Column Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 354-4834.

#### Personals/continued

James P. Spell announces the relocation of his office to 971 Lakeland Drive, Suite 1459, Jackson.

Plez Tinsley, Jr., announces the relocation of his practice to 10 Arrowwood Drive, Suite C, Ithaca, NY.

Steven E. Zachow of Jackson has been reappointed by the Mississippi State Board of Health to the Mississippi Radiation Advisory Council, representing the MSMA. This appointment is for a 3-year term expiring in August 1997.

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#### References:

- A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
- A. Morales et al., The Journal of Urology 128. 45-47, 1982.

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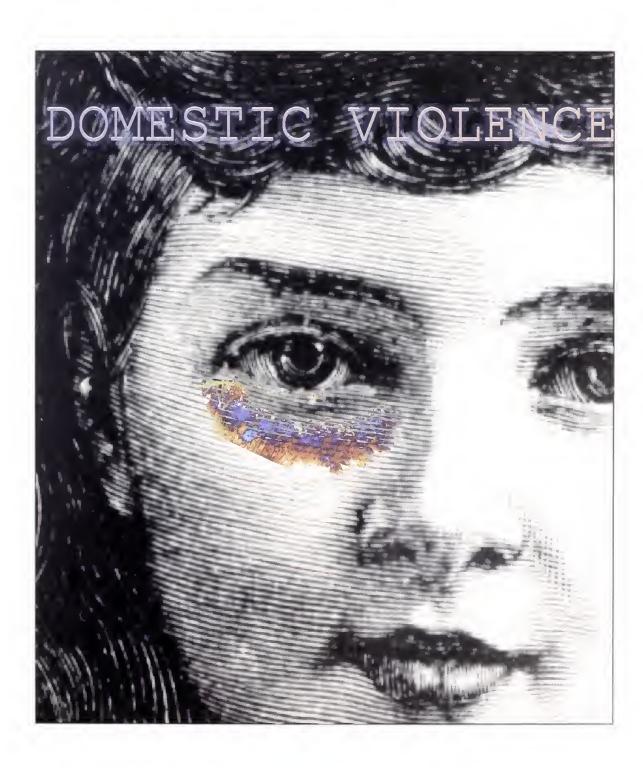
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# Clinical Evaluation for Colonic Polyps: Usefulness of Signs and Symptoms in Diagnosis

WILLIAM H. REPLOGLE, PhD MELANIE D. PAGE, MD BILLY W. LONG, MD JOHN J. BARTKO, PhD

olorectal carcinoma is the second leading cause of cancer death in the United States with an estimated 149,000 new cases to be diagnosed in 1994.1 In an effort to reduce the mortality of colorectal cancer, the American Cancer Society (ACS) has recommended the use of screening sigmoidoscopy for asymptomatic patients beginning at age 50.2 One rational for this recommendation is that early detection and removal of adenomatous polyps may prevent colorectal cancer since most or all colorectal cancer has its genesis in such lesions. It is also assumed that early detection and removal of colorectal cancer improves the patients prognosis. There remains, however, considerable controversy as to the effectiveness of screening sigmoidoscopy.3-4 Ten years after the publication of the ACS guidelines,

This article reports a prospective cross-sectional study of the relationship between various signs and symptoms commonly ascribed to colorectal cancer and the presence or absence of colonic polyps found by colonoscopic examination. Of the 166 patients who participated in the study, 96 were positive for colonic polyps and 70 were negative. There was a significant increase in risk for adenomas polyps as age increased among males. For females, the step-wise logistic regression indicated that an absence of abdominal pain/cramping (p < .01), a change in stool shape (p < .01), and a history of colorectal polyps (undifferentiated) in first-degree relatives (p < .05) were associated with adenomatous polyps.

only 23% of primary care physicians follow or exceed the ACS recommendations regarding the proctoscopic examination.5 Among the physicians who disagreed with ACS recommendations, the most frequently cited reason was that the procedure should be used only for symptomatic patients. This strategy for patient selection presupposes that the presence or absence of symptoms is associated with the presence or absence of colonic polyps. Many of the symptoms of colorectal polyps or cancer, however, commonly occur in apparently well individuals.6-8 Because these symptoms appear to be prevalent among healthy individuals, their predictive value with respect to colorectal polyps or cancer is theoretically reduced. The physician's dilemma is further complicated by the lack of empirical evidence regarding the association between signs and symptoms and colorectal polyps or cancer. Although many standard gastrointestinal texts suggest that "most" colon polyps are asymptomatic, none cite empirical research that quantifies the amount or supports this contention in general.9-11 Accordingly, the purpose of this study was to establish the association between signs and symptoms commonly ascribed to colorectal polyps or cancer and the presence or absence of colorectal polyps.

## METHODS Subjects

Subjects for the present study were patients of a private gastroenterology group practice who presented for colonoscopic examination. Patients presented for colonoscopic examination based on complaints referable to the lower gastrointestinal tract, a family history of colon cancer or polyps, a positive stool hemocult, or suspicious x-ray findings. Inclusion criteria was age of 21 years or greater. Exclusion criteria were: history of familial polyposis or ulcerative colitis; diagnosis of colonic polyp or Crohn's disease within the previous 12 months; and diagnosis of colonic neoplasms within the previous 4 years.

Two hundred five patients presented for colonoscopic examination during the study period. One hundred sixty-six patients met the inclusion criteria, and no patients refused to participate in the study. The study group consisted of 63 males and 103 females. There were 20 blacks and 146 whites. The mean age of the group was 57.4 (S.D.=17.3) with a range of 21 to 87 years of age.

#### **Procedures**

All patients were interviewed prior to colonoscopic examination by the same interviewer to obtain the following information: age, sex, race, self-report of history of cancer (colon and other) in first degree relatives, history of colon polyps in first degree relatives, history of melena, hematochezia, rectal bleeding, mucous in stools, change in bowel habits, change in stool shape, abdominal pain/ discomfort, weight change, smoking behavior, and, for females, personal history of breast, ovarian, and endometrial cancer. All colonoscopic examinations were performed by board-certified gastroenterologists. Tissue samples were graded by board-certified pathologists who were blinded to the purpose of the study. Cases were recorded as positive if one or more adenomatous polyps were found or negative if no adenomatous polyp was found. This resulted in 52 patients (24 males, 28 females) being assigned to the "positive" group and 114 patients (39 males, 75 females) being assigned to the "negative" group. The diagnoses for patients negative for adenomatous polyps are found in Table 1.

Table 1 — Diagnosis/findings at colonoscopy among the non adenomatous polyp group

	Males	Females	Total
	(n=39)	(n=75)	(n=114)
Hemorrhoids	12 (30.7) -	28 (37.3)	40 (35.1)
Fissure	0 (0.0)	1 (1.3)	1 (0.9)
Diverticulitis	9 (23.0)	19 (25.3)	28 (24.6)
Ulcerative colitis	2 (5.1)	1 (1.3)	3 (2.6)
Crohn's colitis	2 (5.1)	1 (1.3)	3 (2.6)
Melanosis coli	0 (0.0)	2 (2.6)	2 (1.8)
Inflammed mucosa	7 (41.2)	10 (58.8)	17 (14.9)
Colonic ulcer	2 (5.1)	1 (1.3)	3 (2.6)
Irritable bowel syndrome	6 (15.3)	10 (13.3)	16 (14.0)
Hyperplastic, pseudo or inflammatory polyp	13 (33.3)	27 (36.0)	40 (35.1)
TOTAL*			153

<sup>\*</sup>TOTAL greater than group size due to multiple finds per patient.

Column percents.

#### Analysis

Previous studies have reported an increased prevalence of colonic neoplasia in general,<sup>12</sup> adenomatous lesions,<sup>13</sup> and colorectal cancer<sup>14</sup> among males. Although separate risk factors for males and females have generally not been emphasized, Johnson<sup>12</sup> et al. has recommended that separate risk factors be established to account for this gender bias. Accordingly, all analyses were performed separately for males and females.

Since age is a fundamental component of the ACS recommended guidelines for screening, we first assessed the ordinal/trend relationship of positive findings and age for the males and females separately. With a 3 (age categories) by 2 (positive/negative findings) chi square table, the Mantel-Haenszel test for linear association was used. 15 Stepwise logistic regression was also employed in the analysis. Predictor variables submitted to regression analyses were age, sex, race, self-report of history of cancer (colon and other) in first degree relatives, history of colon polyps in first degree relatives, history of melena, hematochezia, rectal bleeding, mucous in stools, change in bowel habits, change in stool shape, abdominal pain, weight change, and smoking behavior. A personal history of breast, ovarian, and endometrial cancer was also included in the analysis for females. The dependent variable was the presence (positive) or absence (negative) of adenomatous polyp(s) on colonoscopic examination. All interval scale variables are reported as the mean + SD. An alpha of .05 was used to determine significance.

#### Results

The proportion of positive findings by age group is given in Table 2. The Mantel-Haenszel (M-

Table 2 — Colonoscopic findings by age groups

		Age		
	<50	50-69	=>70	
MALES*	n (%)	n (%)	n (%)	
Positive	5 (22.7) -	7 (35.0)	12 (57.1)	
Negative	17 (77.3)	13 (65.0)	9 (42.9)	
FEMALES				
Positive	5 (15.2)	12 (32.4)	11 (33.3)	
Negative	28 (84.8)	25 (67.6)	22 (66.4)	

<sup>\*</sup> Mantel-Haenszel, p <.05.

H) chi square test for linear association that assesses the increase in positive findings with the increase in age was significant among the males [M-H=5.28, df=1, p<.05] but was statistically non-significant among females [M-H=2.72, df=1, p>.05].

Separate stepwise logistic regression analyses were performed for males and females. For males, patient age [Wald(1) = 5.74, p < .02] was the first and only predictor variable to enter the equation. The proportion of positive findings increased as age increased. This was consistent with the Mantel-Haenszel test among males. The prediction equation based on the logistic regression correctly classified 68.25% of the male patients, with sensitivity and specificity of 45.8% and 82.1%, respectively.

For females, abdominal pain/discomfort [Wald(1) = 10.79, p < .01] was the first predictor variable to enter the equation. Unexpectedly, a higher proportion of patients with abdominal pain was negative on colonoscopy than patients without pain. Change in stool shape [Wald(1) = 9.74, p <

.01] entered the equation on step two. The third and last predictor variable to enter the equation was history of colorectal polyps in first degree relatives [Wald(1) = 4.67, p < .05]. The resulting prediction equation correctly classified 79.4% of the female patients, with sensitivity and specificity of 35.7% and 94.7%, respectively.

#### DISCUSSION

In an autopsy survey by Rickert<sup>13</sup> et al. adenomatous lesions of the large bowel were more likely to occur in males although both genders' risk increased with age. In this study, results of the Mantel-Haenszel (M-H) test for linear association and logistic regression indicated an increased risk for adenomas polyps as age increased among males.

Sondik<sup>16</sup> has reported gender-specific rates for cancer of the colon and rectum. The prevalence for males and females was almost identical through age 40. For ages 50-54, 60-64, and 70-74, however, the prevalence for males was 23.5%, 56.0%, and 41.3%, respectively, higher than for females. The present finding of a differential increase in adenomas pol-

Column percents.

yps among males is consistent with the general trend for gender-specific prevalence of colorectal cancer reported by Sondik.16 Our analysis of the data presented by Rickert<sup>13</sup> et al., however, indicates a significant linear association (M-H) between age and prevalence of adenomas polyps for both males [M-H = 23.7, df = 1, p < .01]and females [M-H = 13.6, df = 1,p < .01]. The increase for females was less pronounced, similar to the present finding. In this series the failure to find a significant relationship with age may be due to inadequate power to detect the more subtle increase in prevalence among females.

Abdominal pain or cramping is usually associated with large polyps that may intussuscept.10 In our study, however, a higher proportion of females with abdominal pain was negative on colonoscopy than females without pain. In a survey of apparently healthy individuals, Thompson and Heaton<sup>8</sup> and Drossman<sup>7</sup> et al. reported the prevalence of abdominal pain to be 20.6% and 54.1%, respectively. Thus, this symptom appears to be relatively common and nonspecific. It is important to note, however, that this pain is one of the two most common presenting symptoms of colorectal cancer. 17

The present study found a significant relationship between change in stool shape and the presence of an adenomatous polyp among females. A decrease in stool caliber is frequently associated with lesions in the distal colon." Large bulky polyps in the distal colon would provide the most obvious explanation for a change in stool shape. Unfortunately, the size of polyps found in this investigation are not available. Without such data, it is impossible to determine if polyps in the distal colon of the positive group were of sufficient size to provide a plausible

explanation for the reported change in stool shape. Although difficult to interpret, this finding warrants further investigation.

Compared to the general population, patients with a first degree relative with colorectal cancer have a two to three-fold risk of developing colorectal cancer. 18-20 Current evidence suggests an inherited susceptibility to adenomatous colonic polyps as well as colorectal cancer.21,22 The present study found a significant association between the presence of an adenomatous polyp and female patients with a history of colorectal polyps (undifferentiated) in firstdegree relatives. While our study was not designed to address the issue of genetic versus environmental risk factors, results do lend support to the notion of familial aggregations of colorectal polyps, at least among females. This finding is consistent with Cannon-Albright's et al.22 recommendation that first-degree relatives of persons with adenomatous polyps be selectively screened.

As noted earlier, the most frequently cited reason for disagreeing with ACS recommendations for sigmoidoscopy was that the procedure should be used only for symptomatic patients. McPhee<sup>23</sup> et al. also reported that physicians were more likely to screen selectively patients positive for signs and symptoms of colorectal cancer. Numerous studies, however, have demonstrated that various gastrointestinal complaints appear to be relatively common in apparently healthy individuals. 6-8 Because of the relatively high prevalence of these signs and symptoms in the general population, their utility in the diagnosis of colonic polyps has been questioned.

Compatible with this previous research, the results of our study indicate that signs and symp-

toms associated with colonic polyps may be relatively nonspecific among patients seeking medical care for gastrointestinal complaints. Signs and symptoms appear to be of limited value in predicting the presence or absence of colorectal polyps. The physician who investigates only on the basis of symptoms may have a false sense of security. However, we do suggest that females with first-degree relatives who have colorectal polyps and older males be viewed with a higher index of suspicion. Hopefully, additional studies in this area will confirm these suggestions.

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## Clinicopathologic Conference VII

Selection and Preparation: Charles A. Brown, MD Kurt D. Olinde, MD

Joe C. Files, MD, Editor

Differential Diagnosis: Swink Hicks, MD
Radiological Findings: Donna Launey, MD
Pathological Findings: Virginia Read, MD

#### CASE PRESENTATION

The patient is a 38 year old white female, gravida II, para II, occupational therapy student who had previously been in good health until she presented to her local doctor in June of 1992 with a complaint of irregular menses prior to developing total amenorrhea which she has had since. She also complained of malaise and fatigue. On her initial physical exam she was noted to have normal vital signs and a 1cm firm right thyroid nodule. The rest of her physical exam was unremarkable. Her initial evaluation included thyroid function studies which were reported to be compatible with hypothyroidism. She had a thyroid scan performed which revealed "no cold nodules". She was placed on L-thyroxine and was seen in follow-up every two to three weeks. She initially felt better but continued to have malaise and fatigue which became worse. She also noticed a decrease in her appetite and some weight loss. Between June, 1992, and December, 1992, she lost approximately 25 lbs., going from 125 down to 100 pounds. In follow-up visits she was noted to have normal thyroid function tests although she continued to feel worse symptomatically. She also noted that her skin started

becoming darker, even in areas which were not sun exposed. Her weight loss, malaise, and fatigue continued until she could no longer attend her classes. She presented to student/employee health in December of 1992 for a second opinion.

At her student health evaluation, she complained of increased hyperpigmentation, continued amenorrhea, and stated that she felt "light-headed" when she stood. She reported compliance with her L-thyroxine dose of 0.05 mg per day. She is the mother of two children and had had normal development and no medical problems up until her present illness. Her age of menarche was 11. She had no history of any surgery. She had no allergies. She took no other medications other than her thyroid replacement.

Initial physical exam revealed a blood pressure of 88/60, a temp of 97.6, a respiratory rate of 18, and a heart rate of 120. Generally, she was alert and oriented X 4 but was chronically ill-appearing.

Head and neck exam revealed a non-tender lcm right thyroid nodule.

Her heart and lungs were normal.

Abdominal exam revealed her to be thin but with no organomegaly or tenderness. She had normal bowel sounds. Genito/urinary exam revealed normal female genitalia and normal hair distribution.

Breast examination is not recorded.

Her neurological exam was normal.

Initial laboratory evaluation revealed a serum sodium of 131, potassium of 4.2, CO2 combining power of 24, BUN 25, creatinine 1, glucose 86, calcium 9.7, phos 6.0, magnesium 1.9, albumin 4.1, total protein 6.7, alk phos of 73, SGOT 46, SGPT 34, and total bilirubin of 0.5.

Dr. Hicks: In discussing this case, I thought it would be best to form a problem list, listing the problems in the order in which they appeared chronologically. Her initial problem was that of secondary amenorrhea. The differential diagnosis of secondary amenorrhea is quite extensive and complicated and for that reason I shall address only a few of the more common causes. Diseases of the pituitary-hypothalamic axis can certainly cause amenorrhea. This patient had no symptoms such as headache or visual field defects to suggest that she had a space-occupying lesion of the pituitary. She also had no symptoms of any tumor of the pituitary which might be hypersecreting such as a growth hormone secreting or an ACTH secreting tumor. There is nothing to suggest that she had a prolactinoma, although a specific history of galactorrhea should have been elicited. The eating

disorders, particularly anorexia nervosa, extreme exercise and psychic stress can all interfere with the hypothalamic pituitary axis. However, she had no history that would suggest any of these as a contributing factor. She apparently was not taking oral contraceptive agents and her negative B-HCG rules out pregnancy. There were apparently no physical signs of excess androgen production. The examination of her ovaries and uterus was apparently normal. She could have isolated ovarian failure due to a number of causes. With the information that we have I feel that her secondary amenorrhea was probably due to a related endocrine disorder. However, I would like to know the results of her luteinizing hormone, follicle stimulating hormone and prolactin levels. Primary hypothyroidism occasionally causes amenorrhea, but is more likely to cause menorrhagia. However, I would think that if her menstrual difficulties were solely due to hypothyroidism they would have corrected after six months of treatment with thyroid hormone replacement.

Her next problem or complaint seemed to be that of malaise, fatigue, and weight loss. Differential diagnosis of these non-specific systemic complaints is also very extensive. The lack of any history of fever or chills leads one against an infectious or inflammatory etiology for these complaints. One would also worry about an occult malignancy. However, with no other evidence at this point to suggest an occult malignancy, I would not have searched for one at this point. There was nothing in her history to suggest that she was depressed. An eating disorder would again enter the differential diagnosis and obtaining a history in these cases can sometimes be difficult. Of course, endocrine dysfunction must again be considered. The fact that her symptoms did not improve, but in fact got worse even though she was on thyroid hormone replacement, makes it unlikely that these symptoms were due solely to hypothyroidism.

Her next problem was the thyroid nodule and the abnormal thyroid test which have already been mentioned. It seems fairly clear that she did have primary hypothyroidism. The only information we are given about the thyroid scan is that the nodule was "not cold". It might be beneficial to repeat that scan and perhaps consider a fine-needle aspiration of the nodule unless it is noted to be hyperfunctioning. It would also be helpful to obtain anti-thyroid antibodies. At any rate, her hypothyroidism seems to have responded well to thyroid hormone replacement and I believe that her TSH returned to normal.

Her next very notable problem is that she became progressively hyperpigmented, even in nonsun exposed areas. The differential diagnosis of diffuse hyperpigmentation is really not very extensive and includes Addison's Disease in which the etiology is attributed to increased melanocyte stimulating hormone and ACTH. These patients may develop diffuse hyperpigmentation with accentuation in body folds and palmar creases. It would be important to know if she did have more pigmentation in these areas. Hemochromatosis can also cause diffuse hyperpigmentation due to deposition of iron and increased melanin in the skin. However, as opposed to the deep tan which the Addison's patients develop, these patients are more likely to have a metallic gray-brown appearing hyperpigmentation. There was nothing in her history to suggest that she had hemochromatosis. Specifically, there was no evidence of liver disease or glucose intolerance. My index of suspicion would not be high enough to pursue this diagnosis any further. Chronic arsenic exposure can also cause hyperpigmentation through stimulation of melanin synthesis in the skin. However, there are usually additional skin findings consisting of generalized hyperpigmentation with small areas of depigmented macules as well as hyperkeratosis of the palms and soles. Here again, without any further evidence of this I would not pursue this diagnosis further.

Her hypotension and mild pre-renal azotemia suggest at least a component of volume depletion. There was no history of decreased fluid intake or blood loss. She apparently had not been on diuretics. She was also noted to be hyponatremic. This would put her in the category of hypovolemic/hyponatremia. Some urine electrolytes and urine and serum osmolarities would be helpful. If the urine sodium were inappropriately elevated, one would be concerned about either a salt losing nephropathy or adrenocortical insufficiency. Diuretics could also do this. For that reason, I think it would be a good idea to check some urine electrolytes and serum and urine osmolarities.

She had a mild normochromic/normocytic anemia which I shall attribute to anemia of chronic disease and not pursue further. She also had an abnormal white blood cell count differential with slightly elevated eosinophils.

A unifying hypothesis that would explain her systemic symptoms, hyperpigmentation, hyponatremia, hypotension, amenorrhea, and mild hypereosinophilia would be adrenal insufficiency or Addison's Disease. Clinical features of primary adrenocortical insufficiency include weakness and

fatigue (incidence approaching 100%), weight loss (incidence approaching 100%), anorexia (incidence approaching 100%), hyperpigmentation (92%), hypotension (88%), non-descript gastrointestinal symptoms (56%), salt craving (about 20%), and postural symptoms (10-15%). This patient certainly had weakness, fatigue, weight loss, hyperpigmentation, and hypotension. I would like to see a baseline ACTH level and then would do an ACTH stimulation test. If the diagnosis of Addison's disease is the correct one, one would expect to see an elevated ACTH level. The classic response to ACTH stimulation would be a low baseline cortisol level and no increase 30 minutes after ACTH administration.

Since this patient has evidence of hypofunction in at least two major endocrine organs one must consider the possibility of one of the multiple endocrine gland hypofunction syndromes. These have been divided into two major categories, the first being multiple endocrine deficiency syndrome or Schmidt's Syndrome, and the second polyglandular deficiency with mucocutaneous candidiasis. Because the second large category usually presents in childhood and is associated with mucocutaneous candidiasis we'll not discuss it any further. Schmidt's syndrome is characterized by several autoimmune endocrine deficiencies. Hypoadrenalism, hypothyroidism, and type I diabetes are all common. Gonadal failure, which would be possible in this patient, is less common. Here again measuring her central gonadotrophins would be necessary and helpful in further discerning the cause of her amenorrhea. Hypoparathyroidism and pituitary insufficiency are both rare in Schmidt's syndrome but have been reported. The onset of Schmidt's syndrome is usually in adult life. Other associate autoimmune disturbances which have been reported include pernicious anemia, Celiac disease, myasthenia gravis and isolated red blood cell aplasia. It should also be noted that there is a strong female predominance in this clinical syndrome. Inheritance is usually sporadic but there are certain HLA haplotypes that may increase one's susceptibility.

In summary, I feel that this patient certainly has primary hypothyroidism and hypoadrenalism. I've already covered the diagnostic studies that I would do. As far as treatment goes, I would continue her thyroid replacement and as soon as the diagnosis of adrenal insufficiency had been made I would, of course, start glucocorticoids and mineralocorticoids. Unless her laboratory profile indicates otherwise, I would attribute her secondary amenorrhea to her other endocrine dysfunction and presume that it would improve with replacement of those hormones. I

would certainly follow her closely for development of other endocrine disorders. Patient education, particularly about the need for extra glucocorticoids as well as IV fluids during times of stress, would be very important.

Additional Laboratory Data:

LH <1.0 miu/ml

6.24 miu/ml (14.8 - 138) Post

menopausal

Cortisol 0.7 ugm/dl 5-20ug/dl

Aldosterone < 2.5 ng/dl 4-31

Post ACTH:

**FSH** 

Cortisol 0.5 ugm/dl Aldosterone<2.5 ng/dl

ACTH 358 Pg/ml <70pg/ml

There is no pertinent radiology information.

**Diagnosis:** Polyglandular autoimmune deficiency syndrome □

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- Dr. Brown and Dr. Olinde were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1992-1993.

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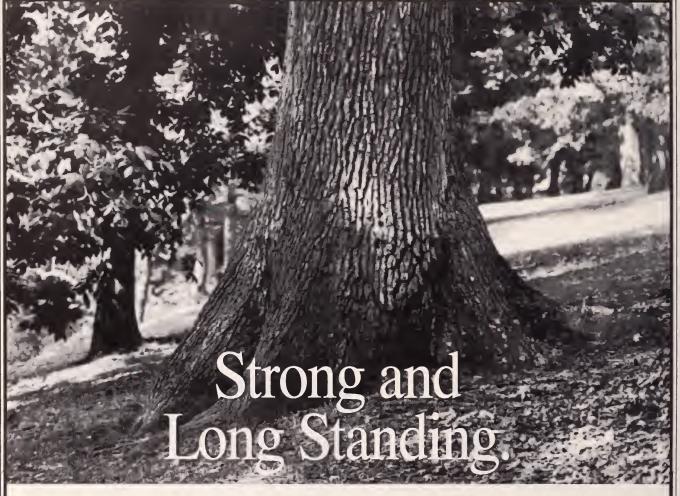
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# **Mississippi Foundation for Medical Care**

# Gallbladder Surgery for Medicare Patients in Mississippi

ALTON B. COBB, M.D., M.P.H., Principal Clinical Coordinator NENA SANCHEZ, M.S., Statistician DEBBIE MILLER, ART, Analyst Mississippi Foundation for Medical Care, Inc. Health Care Quality Improvement Program

Mississippi Foundation for Medical Care (MFMC) conducted a review of gallbladder surgery performed on Mississippi Medicare Patients using hospital claims files and limited record review for verification of claims file data.

Significant error rates in the surgeon identification number were found in the claims files. It should also be noted that the current ICD-9-CM coding system does not allow for identification of laparoscopic cholecystectomies converted to open procedures. Past studies have attempted to use claims data alone for these types of analyses. These findings demonstrate the importance of using caution by those attempting to use claims data (without verification) to define patterns of hospital utilization, clinical outcomes and/or physician profiling. Claims data must be tested for validity for reliable pattern analysis.

In addition, considerable variation was found among providers in elements such as conversion rates, complication and readmission rates. A few surgeons showed patterns for critical variables that were quite different from the universe. There was however, no statistically significant differences associated between volume of cases performed and outcomes.

Time frame comparisons over several years show significant (> 80%) increase in gallbladder surgery since the introduction of the laparoscopic procedure.

he Health Care Financing Administration (HCFA) and the peer review organizations (PROs) nationwide have undertaken major changes in the PRO program and its role of quality improvement and oversight for Medicare patients. These changes are based on studies and recommendations from the Institute of Medicine and other research studies which show that improvements in care will more likely result from a projectoriented, cooperative and educational approach than from the traditional individual case review focus.

In effect, these changes are intended to de-emphasize the importance of outliers on the curve of a normal distribution. Modifying the entire curve to narrow inappropriate variations in physician practice patterns by incorporating clinical guidelines and principles of continuous quality improvement (CQI) has become the new goal. CQI efforts will involve building collaborative relationships between PROs, physicians and hospitals focusing on continuing medical education.

The focus has shifted from a concern for identifying quality of care issues through individual case review to a goal of identifying opportunities for improving the care and outcomes for Medicare patients through clinical pattern analysis. These patterns may identify opportunities for improvement in health care access, utilization, and/or quality of care. Based on these identified opportunities, focused clinical improvement projects will be implemented on a cooperative basis with hospitals and their medical staffs.

Clinical improvement projects may come from pattern analysis using Medicare claims data; from case review; or from physicians or hospital staff members who identify an area of care that appears to offer an opportunity for improvement in quality or outcome. Topics may also come from medical literature or from HCFA. These projects utilize data analysis, clinical guidelines or parameters and the principles of continuous quality improvement.

### GALLBLADDER PROJECT

As part of its program of Clinical Improvement Projects under the PRO's Fourth Scope of Work, the Mississippi Foundation for Medical Care (MFMC) reviewed the gallbladder surgeries of Mississippi Medicare patients. Cholecystectomy is a frequently performed procedure and in Mississippi accounted for some 1.4% of the total Medicare admissions to hospitals during the January 1, 1992, through June 30, 1992, time period. MFMC was concerned with research findings that detailed possible problems with the introduction of laparoscopic cholecystectomy.

In a study conducted in New York state<sup>1</sup>, the complication rate of laparoscopic cholecystectomy among Medicare patients was found to be 23.68% compared with a 5.1% complication rate in a large study of all cases reported by the Southern Surgeons Club.<sup>2</sup>

The laparoscopic procedure for gallbladder surgery was introduced quite rapidly in the United States and was not subjected to well designed research studies to test its associated complications and long-term outcomes as compared to the traditional open procedure. Thus, the introduction of the laparoscopic method for this surgery has raised issues concerning case selection, surgeon credentialing, complication rates and other issues.

The initial data for this study was supplied by HCFA. The claims

files contain case specific information which included data on comorbidities (conditions on admission in addition to principle diagnosis) and complications (conditions developing during the hospital stay). MFMC used the data to profile hospital and condition specific complication rates, average length of stay, readmission rates and other indicators which may show patterns of care and outcomes that display variation and may suggest opportunities for clinical improvement projects.

#### A SURVEY OF FINDINGS

Since the introduction of the laparoscopic procedure for gallbladder surgery, the proportion of all cases performed using this technique has progressively increased. During the six month study period January 1, 1992-June 30, 1992, MFMC reviewed the operative reports on 1,028 cases. Sixty Mississippi hospitals reported performing cholecystectomies; 52 hospitals performed both laparoscopic and open procedures. Eight hospitals performed only open procedures. There were 152 surgeons involved in these procedures; 129 performing both laparoscopic and open procedures. Twenty-three surgeons performed only open cholecystectomies.

MFMC reviewed the operative reports on these 1,028 cases to verify UPIN numbers (surgeon identification) and to verify the surgical approach since the current ICD-9-CM codes do not adequately distinguish conversion cases. (Cases started laparoscopically but converted to open are coded as open) Data on the distribution by surgical approach is displayed in Table I.

The laparoscopic approach was attempted in 763 (74.22%) of

TADIET	DISTRIBUTION BY TYPE	OF CUDCICAL	ADDDOACIT
LABLE I —	DISTRIBUTION BY TYPE	OF SURGICAL	APPROACH

	OPEN	%	LAP	%	TOTAL
INITIAL APPROACH	265	25.78	763	74.22	1028
# CONVERTED	+ 124		- 124		
FINAL APPROACH	389	37.84	639	62.16	1028

CONVERSION RATE = # CONVERTED / # LAPS (INITIAL APPROACH) \* 100 = 124 / 763 \* 100 = 16.25

cases; 124 of these cases were converted to an open approach during surgery (conversion rate of 16.25%). The final approach was 389 (37.84%) open and 639 (62.16%) laparoscopic.

Conversion rates by surgeons showed significant variation. Among surgeons performing 10 or more procedures the highest conversion rate was 31.82% (7 of 22 cases) and the lowest was 0% (0 of 18 cases). One surgeon performing 7 procedures converted 6, and a number of surgeons performing < 10 procedures converted over 50% of cases. One surgeon converted 3 of 3 procedures.

Conversion rates (Table II) varied considerably by sex. Among

male patients the conversion rate was 22.47%; among females the rate was 13.62% (Chi Square = 9.1715 p-value = .0025). Further analysis revealed that there was no age by sex differences in the open, lap or converted procedures (p-value = .4609, .0602, and .9477, respectively). Age can be considered an attribute for the differences in the conversion rate but does not completely explain the disparity. Therefore, male gallbladder patients were probably more likely to have conditions in addition to age which lead to conversions from the laparoscopic approach to open procedures.

The NIH Consensus Statement on Laparoscopic Gallbladder Sur-

gery<sup>5</sup> served as the Clinical Guideline or Parameter for this project. The Statement takes the position that conversions must be considered on an individual basis in respect to factors such as appropriateness of care, and case selection. The Statement states that many conversions are indicated and in the best interest of patient care.

One hypothesis tested was the reported association in other studies between volume of procedures performed by surgeon or hospital and the coded complication rates. The analysis did not show a statistically significant relationship between increased volume of procedures by provider and lower

# TABLE II — DISTRIBUTION OF CHOLECYSTECTOMIES BY INITIAL SURGICAL APPROACH AND GENDER

	OPEN	LAP	TOTAL	CONVERTED	
MALE	109	227	336	51	
%	32.44	67.56	100.00	22.47	
FEMALE	156	536	692	73	
%	22.54	77.46	100.00	13.62	

complication rates. However, there were a small number of providers having complication rates which varied considerably from the remainder. These cases will be reviewed individually to test for clinical significance.

Readmission rates and average length of stay also varied considerably among providers. Since the number of cases and events were often small, no statistically significant patterns were observed. The MFMC is conducting case review for clinical significance of a small number of cases related to complication rates, readmission rates and the average lengths of stay.

A pattern of UPIN errors was found for several hospitals. The surgeon identified in the claims file database was not the surgeon performing the cholecystectomy in 14% of all cases. Several hospitals showed error rates of more than twice that percentage and have been participating in a project to address this issue. These findings emphasize the importance for accuracy in administrative and clinical databases that may be used for pattern analysis or profiling.

The NIH Consensus Statement on Laparoscopic Gallbladder Surgery states that the introduction of the laparoscopic method has not changed the appropriate indications for gallbladder surgery. MFMC measured the rate of frequency of this surgery in a period prior to the introduction of the laparoscopic procedure and compared this pre-laparoscopic rate with a more current rate as shown in Table III.

For Medicare Mississippi patients, the incidence rate for gall-bladder surgery during 84/85 was 3.87/1000 beneficiaries and during 91/92 this rate had increased to 7.22/1000 beneficiaries or about an 87% increase in frequency rate for this procedure. It should be noted that the overall surgery rate increased from 189/1000 beneficiaries to 204/1000 beneficiaries during the same time frames.

NOTE: Medicare eligibility data was available back to the year 1987. The number of eligibles for July 1, 1984 through June 30, 1985 was estimated based on the percentage of change between the last two available years of data.

#### DISCUSSION

It is difficult to make valid statistical comparisons between various clinical outcome indicators for laparoscopic and open cases due to case selection bias. It appears likely that, in general, patients with fewer potential complications are selected for the laparoscopic procedure and those with poorer surgical risk factors are selected for the open procedure. The data shows considerable variation in conversion rates by surgeon, but without more information dealing with the condition of each patient and problems experienced during surgery, judgments cannot be made on the appropriateness of these conversions.

MFMC identified an opportunity for improvement related to inaccurate UPIN numbers, since several hospitals had error rates exceeding 25%. Also identified were patterns of complication and readmission rates which are being reviewed on an individual case basis.

Perhaps the major finding is that the frequency of gallbladder surgery in the Medicare population in Mississippi has increased dramatically over the last several years. Between FY85 and FY92, the incidence rate for this surgical procedure increased from 3.87/ 1000 beneficiaries to 7.22/1000 beneficiaries, or an increase of 87%. Since the NIH Consensus Statement asserts that the indications for gallbladder surgery have not changed the increase in frequency of this surgical procedure is questioned.

One may suggest various hypotheses to explain this increase in the incidence of gallbladder sur-

TABLE III — INCIDENCE RATES FOR GALLBLADDER SUF	GERY
MEDICARE BENEFICIARIES	

ALL CHOLECYSTECTOMIES					
TIME FRAME	# ELIGIBLE BENEFICIARIES	# CHOLE	RATE PER 1000 BENEFICIARIES	CHANGE PER 1000	
7/1/84-6/30/85	333,554	1290	3.87		
7/1/91-6/30/92	370,434	2673	7.22	+ 3.35	

gery. One of the most popular is that upon the introduction of the laparoscopic technique there existed a backlog of patients with gallbladder disease who met the indications for surgery but who had not had surgery due to the long hospital stay and convalescence associated with the open procedure. If this hypotheses is correct, the incidence rate for this procedure should tend to level off over time.

Another possible explanation is that surgeons are recommending this procedure more often for persons with borderline indications who are good candidates for the laparoscopic procedure. The real reasons for the increase probably are a combination of the two hypotheses.

> Post Office Box 4665 Jackson 39296-4665

Acknowledgment: The research involved in this study was supported by the Health Care Financing Administration Health Care Quality Improvement Program.

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Dr. Cobb, MFMC's principal clinical coordinator, served as the state health officer and headed the Mississippi Department of Health for almost 20 years before bringing his health care experience to MFMC.

Nena Sanchez joined MFMC in 1993

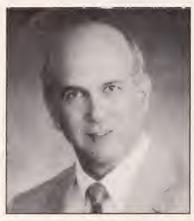
as statistician. She received a Bachelor of Science in statistics in 1991 and a Master of Science in statistics in 1993 from Oklahoma State University.

Debbie Miller joined MFMC in 1980 as a medical care evaluation assistant and has since served as profile analysis coordinator, data department manager and is currently data analyst for the Health Care Quality Improvement Program.

25-401-0011



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The President's Page MALLAN G. MORGAN, MD

# "And Justice For All"

"fairness is what justice really is." — Justice Potter Stewart
but

"This is a court of law, young man, not a court of
justice." — Oliver Wendell Holmes, Jr.

The two opinions quoted above pretty well illustrate the dilemma in which we of the medical profession find ourselves. Fairness is all we ask of the Mississippi judicial system, but what we are often faced with is an interpretation of the law by the judicial system that to us seems less than fair.

There is a Justice on the Mississippi Supreme Court that is reported to have told his trial lawyer buddies that they don't need to worry about any tort reform bills which might be passed by our state legislature. He will make sure that any such bills will be found to be unconstitutional by the Supreme Court. This is not the fairness nor the justice that we expect from our Supreme Court Justices.

In the November elections we will have the opportunity to vote for members of a Court of Appeals, which will be new in the state of Mississippi. This court, which will hear appeals from the local courts, is supposed to give the Supreme Court more time to consider constitutional issues. But what this means to us is that in addition to divorce suits and property disputes, etc., the Appeals Court will hear malpractice suits. If we are able to assure that fair and just candidates for the Court of Appeals are elected, we will assure ourselves of an unbiased forum that has not been characteristic of the Supreme Court. Since the malpractice cases that are appealed will most likely go before this court, we have an opportunity to protect ourselves and our colleagues from unjust decisions. But if we don't get involved and support the best candidates, we will be paying (literally) for it for years to come.

(Continued on page 300)

# **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 10 OCTOBER 1994

## Are We Really Communicating???

(or the Tale of Dr. Getwell and Mrs. Tallow)

Since day one of medical school wise physicianeducators have hammered into us that "if you listen to the patient long enough, he will tell you the diagnosis." The listening art has truly served us well in the practice of medicine. This aphorism, though immensely helpful in practice, has not eliminated the need for a scan for every organ system, a scope for every orifice and surgery for every offending body part.

The most common thing I hear these days from patients about the sub-specialists I have referred them to goes something like this.... "That doctor you sent me to sure was nice, and he did the scope (scan, surgery) just like you told me he would, but, Doc, I'm here for you to tell me what he found wrong with me and what ya'll want me to do about it"....

If I'm lucky and the specialist's office staff has been expedient with the dictation, I have on the patient's chart a wonderful and enlightening letter regarding their findings. Then I can proceed to translate back to the patient from "medicalese" into hill-country English what the final diagnosis and treatment plan are.

I don't mean to imply that patients rebound in this fashion every time, but it does happen a lot. Primary care physicians have no monopoly on effective patient communications. Time constraints cause me to fall short way too often. A recent incident pointed this up to me quite clearly.

The patient was a 60 year old 5'2" 330 pound lady with uncontrolled hypertension that we'd been battling for about nine months. I had never managed to get her diastolic blood pressure under 110, even on a supposed low-sodium diet and a combination of diuretics, ace inhibitor, and calcium channel blocker. I was just before adding a beta-blocker when I opted to refer her to a Nephrologist. At every visit I had admonished her to diet and particularly to lay off the salt which she always assured me that she was doing. When she came back to me from the specialist her blood pressure was 180/95 with no significant medication change.

What did he do that I didn't do? He had told her and put into writing the following dictum... "You are going to have a stroke if you don't stop eating bacon, fatback, sausage, country ham, souse meat, baloney, potted meat, weenies, and viennas (pronounced vi-ee-ners)". She showed me his handwritten note. The patient expressed mild happiness about her blood pressure reading. I was ecstatic that a dent had been made in her treatment. She complained bitterly, however, that the Doctor I had sent her to was quite simply starving her to death. I learned a pearl of great price that day.

Motivating folks to adhere to a low-fat diet for cholesterol reduction is another daily challenge. I

(Continued on page 300)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

(Continued from page 299)

The leading health, business and industry associations and PACs in Mississippi have been working together for the past nine months to identify and support the best candidates for the new Court of Appeals. The candidates which they have endorsed are:

1st Congressional District:

Post 1 - Tommy Coleman, Ackerman

Post 2 - Roger McMillin, New Albany

2nd Congressional District:

Post 1 - John Frasier, Greenwood

Post 2 - no endorsement

3rd Congressional District:

Post 1 - Greg Snowden, Meridian

Post 2 - John Kelly, Brandon

4th Congressional District:

Post 1 - Leslie Southwick, Jackson

Post 2 - Bobby Delaughter, Jackson

5th Congressional District:

Post 1 - Gene Fair, Hattiesburg

Post 2 - James Thomas, Biloxi

This is serious, this is real, and the election of Justices that might not be fair, and sympathetic, when hearing a malpractice suit could cause our profession a lot of woe for years to come.



MSMA Legislative Forum January 17, 1995 Jackson, MS

127th Annual Session May 17-21, 1995 Treasure Bay Resort & Casino Biloxi, MS hit on this little fable that I tell folks when the importance of it just is not sinking in. While it is a gross over-simplification of the atherosclerotic process, it never fails to impress. I call it my "Burger grease down the drain" talk.

Dr. Getwell to patient: "Okay, just imagine you are frying hamburgers at the stove and they are almost done when the phone rings and who is it but Aunt Flossie who has called with thirty minutes worth of really good gossip. You turn off the eye because it's too good to pass up (in fact, it is considerably juicer than your burgers). When the topic winds down and you return to the stove, you notice a waxy-white substance floating in the skillet next to your burgers. What do you do? Well, you warm them back up and then you have to decide what to do with this skillet of hot grease. Now, I ask you, are you going to pour that hot grease down you kitchen sink?"

Mrs. Tallow to Dr. Getwell: "Heck, no, Doc!" Dr. Getwell: "Why not?"

Mrs. Tallow: "Well, you know, after a while, that grease will build up in my pipes and I'll have big trouble and a big plumbing bill."

*Dr. Getwell*: "Right, and that's exactly what happens to your arteries!"

You can almost see the light-bulb switch on in the air over Mrs. Tallow's head.

I don't want to belabor the point but the things you say to your patient in the closing minutes of your visit are very often the only things carried away with him. You can err a tad at the beginning and get back on course fairly easily, but it's hard to get forgiveness if you screw up your finale. And, never ever leave your patient with the impression that you don't have time for him. Besides being poor practice, it just plain rude.

Brother Doctors - listen long, think fast, explain well, and you will become, at least in the eyes of your patients, the world's greatest doctor.

Dwalia S. South, MD
Associate Editor

# Lines Of Defense: Domestic Violence Awareness Month

America is a nation at war, and the struggle is as close as our own living rooms. Every day we read about gangs battling on our urban streets, the pernicious hold drugs still have on many of our youth and the continuing fight against AIDS. We are less likely, however, to read about the war played out within the American family, where the front lines lie hidden behind the front doors of our communities. This is the battlefield of domestic violence, where the casualties are enormous and the heroes far too few.

It has been said that heroes are those who do what they can. With so much that physicians can do in this crisis, the hour for quiet heroism is upon us. October is Domestic Violence Awareness Month, a chance for us to take stock of our efforts As we do, however, we must remember that for the victims, domestic violence is not merely a month long affair — it is a daily, a weekly and all too often, a lifelong struggle.

By the time you have finished reading this sentence, another woman in the United States will have been beaten, battered and bruised by someone she knows. Every 12 seconds, 24 hours a day, 365 days a year, a woman is punched, kicked, slapped — or worse. Every decade, domestic violence kills as many women as the total number of Americans who died in the Vietnam War.

The damage does not stop, however, with the lives and bodies of women. Domestic violence targets all of the most vulnerable among us, including small children and the frail elderly. Two thousand American children are beaten and starved to death every year, and millions more suffer the horrific effects of ongoing abuse and neglect. It is hard to measure how many millions more victims are ignored or overlooked, because physicians fail to properly identify as many as 95 percent of the victims of domestic violence.

The security of a physician's office may be the only sanctuary the patient can find in a personal

hell of violence and neglect. We have a responsibility — not only as physicians, but as citizens and community members — to create the necessary impact to stem this growing American epidemic.

We must begin with our own awareness of violence in the family. I will never forget the day I met a cardiologist who started a hospital-based treatment center in Kenosha, Wisconsin for abused women.

"I understand you treat battered women," I said as we were introduced.

He replied, "And so do you."

My education began at that instant.

What he meant was that when physicians examine patients with cuts and bruises and broken arms, we may actually be treating victims of abuse.

With a problem as prevalent as domestic violence, the AMA's guidelines for diagnosis and treatment recommend *routine* screening in the primary care setting. We must be on the lookout, because AMA research shows that 80 percent of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. Patients trust their physicians. What physicians need are the right tools, and the AMA has them al hand.

In 1990, we formed the National Coalition of Physicians Against Family Violence, now more than 6,000 members strong. The Coalition keeps physicians informed about resources, model programs, speakers and public education materials. Participants receive the AMA Diagnostic and Treatment Guidelines on child and elder abuse and domestic violence, as well as patient materials bearing the message, "When you break the silence, you begin the cure."

It will take more than openness or good medicine to make the cure complete, however. Physicians should become familiar with the range of resources in the community: shelters, legal advocacy, counseling, support groups, crisis hotlines and your state Alliance. Look also to the extraordinary grass

roots efforts of our own Federation, where physicians like you have already taken this issue to heart. To turn the tide in a war of this magnitude is going to take every available recruit, side by side, attacking on as many fronts as possible. It is going to take lawyers, judges and the police; concerned citizens and local communities; all of us engaged in health care; and the victims themselves — all working together.

To do your share to recognize and treat victims of domestic violence, just keep your professional RADAR turned on:

- Remember to screen your patients about violence.
- Ask questions such as: "At any time, has a partner hit, kicked or otherwise hurt or frightened you?"
- Document your findings. Information in the patient's chart about "suspected domestic violence" can serve a valuable function in court should the

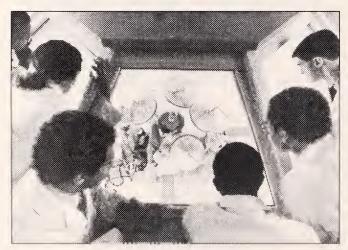
patient seek legal action. A physician's documentation validates the victim's allegations.

- Assess your patient's safety. Is it safe to go home? Find out if any weapons are kept in the house, if the children are in danger and if violence is escalating.
- Review options with your patient. Know about referral options.

Remember, the public entrusts us with their care, and many of us have already chosen to be the heroes that their physical and emotional pain demand. But to gain a beachhead against this national epidemic, there is not a person — or a moment — to spare. As physicians, as citizens, as parents, as sons and daughters, we must work together to break the silence and end the violence, beginning now with Domestic Violence Awareness Month, and throughout this and every year.

Robert E. McAfee, MD, President, American Medical Association

# AN ARMY SCHOLARSHIP COULD HELP YOU THROUGH MEDICAL SCHOOL



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# **Domestic Disturbances Often Result in Death**

A domestic disturbance is the worst call a law enforcement officer receives.

These calls are often the most violent because they are acts of passion. All too often, they result in death.

The Mississippi Medical Examiner's Office recently completed a study evaluating homicides resulting from domestic violence occurring during a six-month period. The definition of domestic violence includes a crime involving people related by blood, marriage, cohabitation, having a child in common or are dating or engaged. Domestic violence does include former relationships such as exhusbands.

Donna Kaye Cassell, a medical student at the University Medical Center, conducted the study as part of a research project under the direction of Dr. Emily Ward, State Medical Examiner (SME).

"Our study was designed to examine the prevalence of domestic violence homicides in Mississippi," said Dr. Ward. "I suspected that a large number of homicides were related to domestic violence. Unfortunately, our data has proved that true." Cassell evaluated autopsies performed by the SME from September 1993 through February 1994. There were 47 homicides and of those, 30 — or 68 percent — resulted from domestic violence. It is important to note, however, that these figures reflect only autopsies performed at the SME in Jackson. Fifteen designated pathologists throughout the state also conduct autopsies at the request of county coroners.

Of the 30 deaths:

- 57 percent were male, 43 percent were female:
  - 70 percent were black, 30 percent were white;
- 83 percent were less than 35 years of age, with the largest percentage 33 percent being 19 to 25 years of age; 27 percent, ages 26-35 years of age; 23 percent, 0 to 18 years of age; 17 percent, over 35 years of age;
- 33 percent of the victims had a positive blood alcohol content and of those 80 percent were

male, 20 percent were female;

— 70 percent of the deaths were caused from a gunshot wound; 10 percent died from stabbing; 6.6 percent from strangulation; 6.6 percent from smothering or suffocation; 6.6 percent from a combination of causes.

Deaths with their roots in domestic violence aren't always homebound, as was discovered in the study, Dr. Ward said. Although 70 percent were in the home, 16.7 percent occurred in a bar, 6.7 percent in either a store or motel; 3.3 percent were at work; and 3.3 percent location unknown.

The SME conducts autopsies at the request of county coroners. Between Aug. 1 and Dec. 30, 1993, the SME in Jackson conducted 108 autopsies and between Jan 1. and July 21, 1994, she has conducted 160.

The domestic violence study is the first of many studies to be initiated by the Medical Examiner's office.

Over the past fifteen months some rather remarkable changes have transpired through the office of the Mississippi State Medical Examiner and the Mississippi Crime Laboratory. In July 1993, Commissioner of Public Safety Jim Ingram appointed Dr. Emily Woffard Ward, a Mississippian and former pathology resident at the University of Mississippi Medical Center, to assume both the position of Mississippi State Medical Examiner (SME) and the Director of the Mississippi Crime Laboratory. Dr. Ward, a graduate of Jefferson Medical College of Philadelphia and a board-certified forensic pathologist, is the first person to ever hold both positions simultaneously. Both agencies are quite similar in function and are two small branches of the Department of Public Safety, so combining the directorships has proven to be a logical and smooth transition. In the next two or three years further efforts will be undertaken to combine both agencies under the Department of Public Safety as the Mississippi Bureau of Forensic Sciences.

Several positive changes have helped the Medical Examiner's office and the Crime Lab move from near turmoil to efficient, cost-effective agencies which serve law enforcement throughout the state in solving violent crimes. A new state-of-the-art morgue

opened in 1992 providing an excellent place to perform medicolegal autopsies by the SME. The morgue, which is under the same roof as the Crime Lab offers the opportunity for all sections of the crime lab to be available when an autopsy is performed. The facility includes room for taking radiographs, a dissecting microscope, photographic equipment, and a computer network to maintain records.

Approximately 10,000 of the 25,000 deaths occurring annually in Mississippi fall under the jurisdiction of the State Medical Examiner system. Most of the deaths are investigated locally by coroners who have undergone training through the office of the SME and who have met basic requirements in the field of death investigation. If the situation warrants an autopsy examination, the coroner can either request the procedure be done locally by a pathologist near where the death occurred or that the body be transported to Jackson to be autopsied by the SME at the state morgue facility. Especially in cases that will result in criminal trials, Dr. Ward's expertise as a forensic pathologist allows the State of Mississippi to offer the most qualified testimony about the cause of death.

The Medical Examiner's Office is greatly indebted to several pathologists throughout the state who help their local coroners. A few of the designated pathologists include Dr. David Steckler of Natchez, Dr. J. D. Rutherford of Hancock County, Dr. Tom McGee of Grenada, Drs. Ben Martin and John Parker of Columbus, Drs. Thomas McLees and Micheal Todd of Alcorn County, and Drs. Thomas Walden and Robert Britt of Brookhaven.

In addition to performing autopsies and assisting coroners with death investigations, the office of the SME is required to maintain files and records on every death under the jurisdiction of the Medical Examiner Law passed by the Legislature in 1986. A data base has been established which allows Mississippi to have a vast array of statistics on a number of different types of violent deaths. Statistics will be available not only on issues such as domestic violence but also drug related fatalities, homicides, traffic fatalities and their association with alcohol, and deaths of infants. These statistics will prove useful to law enforcement agencies, public health officials, health care providers, and the courts.

Working with Dr. Ward in the Medical

Examiner's Office are Paige Shelton, Chief Investigator; Wade Tingle, Forensic Technician; Sam Howell, Forensic Toxicologist; Melissa Schoene, Forensic Technician and Rosie Hines, Receptionist. Ms. Shelton, a former employee of the MSMA, holds a BS degree in Criminal Justice from the University of Southern Mississippi. She set-up and maintains the data base of more than fifteen items recorded on every death that is investigated by a coroner in the state. Additionally, Ms. Shelton organized and directed the first Death Investigation Training School sponsored by the State Medical Examiner and held in Jackson in mid-September. She recently attended the National Association of Medical Examiners meeting where she was elected to affiliate membership. She is the only Mississippian to hold such a position.

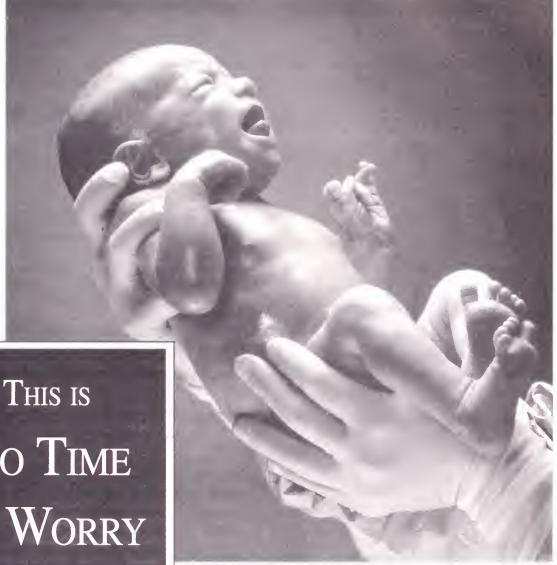
Since Mississippi is the only state in this area of the country to have a comprehensive Medical Examiner Law requiring all deaths to be reported to a central repository, we can look forward to seeing our Medical Examiner System move into the forefront of forensic pathology. The merger of the Medical Examiner's office and the Mississippi Crime Laboratory is a very innovative and unique transition. Dr. Ward is the only physician in the country to be the Director of the State Crime Lab. This standard of expertise and qualification is drawing considerable attention to our laboratory from all parts of the country.

One of the first major projects will be to establish a DNA laboratory to help in the criminal investigation of violent crimes. Another role of the DNA laboratory will be to create a data bank where the DNA of all convicted sex offenders will be entered under the provisions of a newly enacted law passed by the Legislature during the last regular session. Anyone convicted of rape, sexual battery, child molestation, and other such felonies, will be listed in the Mississippi Crime Lab's DNA registry. Should such a convicted felon repeat the offense, the specimens listed in the crime lab registry will immediately link the suspect to the crime.

The employees of the Medical Examiner's office extend to all members of the MSMA an invitation to come and visit the new facility for a tour or assistance on any case where the cause of death of an individual is in question.

**LETTERS, COMMENTS or QUERIES....** The Editors of *Journal MSMA* invite members of the MSMA to comment for publication on any material that appears in the publication or on other current medical issues. If you have a letter, comment or query, please send it to: The Editors, *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229.

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THE DOCTORS' COMPANY

# **Medical Organization**

# Dr. Crawford Named Outstanding Mississippi Family Physician



Dr. Dewitt Grey Crawford, a Louisville physician, received the Mississippi Academy of Family Physicians' highest award at it's recent scientific Assembly held in Gulf Shores, Alabama. The award was presented by Dr. Frank Bowen, president of the MCAAFP.

The Family Physician of the Year Award is given in recognition and appreciation for outstanding leadership and services to Family Medicine in Mississippi. This Award was established in honor of the late Dr. John B. Howell, a longtime member, and delegate to the American Academy of Family Physicians.

Dr. Crawford attended Georgia Tech for a brief time, majoring in Mechanical Engineering, then later changed to Ole Miss majoring in pre-med. He attended medical school at the University

of Mississippi School of Medicine in Jackson and interning at John Gaston Hospital, Memphis, Tennessee. Dr. Crawford returned to his hometown in 1961 to begin practice with his father, Dr. John Albert Crawford.

Drs. John Albert and Dewitt Crawford opened Tri-County Nursing Home in 1972 and served as its medical directors. Dr. Dewitt Crawford is currently a staff member of the Winston County Community Hospital where he served as Chief of Staff: Winston County Coroner; member and medical director of the Winston County Heart Association and Nursing Home Foundation Board; member and past president of the East Mississippi Medical Society: member of American Health Care Association; member of Southern Medical Association; member the American Medical Association and the Mississippi State Medical Association where he serves as a member of the Board of Trustees and on numerous committees.

When nominating Dr. Crawford for the award, Dr. Michael Ard of Louisville said, "He practices good solid preventative medicine and has had a solid doctor-patient relationship with his patients for over 29 years. Although approximately four years ago health concerns forced

him into semi-retirement, Dr. Crawford has remained very active in the health care field in nursing home management and care of his nursing home patients.

One unique feature of this doctor is the fact that he donated his local clinic to the county upon his retirement. That clinic is now the home of a rural health clinic and surgical medical offices. Earlier this year he started back in primary care practice on a very limited basis at this newly established rural health clinic.

Dr. Crawford is active in community service, serving as athletic physician for the local high school for many years and is a member and past president of the Winston Academy Foundation.

As a member of the First United Methodist Church of Louisville he is a choir member and part time director for over 25 years, member of the Administrative Board and past Finance chairman.

Dr. Crawford is an active member of the Mississippi Academy of Family Physicians serving on the Legislative, Long Range Planning and Finance committees and is currently Chairman of the Finance committee.

A native of Louisville, Mississippi, Dr. Crawford is married to the former Peggy Jane Woodward of Louisville. They are the parents of three children, Beth of Dallas, Texas; Jean of Raleigh, North Carolina; Robin of Orlando, Florida, and four grandchildren.

The 600 plus member Mississippi Academy of Family Physicians is an affiliate of the Ameri-

can Academy of Family Physicians (AAFP), the national association representing more than 71,000 family physicians and medical students. The AAFP in Kansas City, Missouri was founded in 1947 to promote and maintain high standards for family doctors providing continuing, comprehensive health care to the public. Dr. Glen Aukerman of Morgantown, West Virginia, Past President of the American Academy of Family Physicians was guest speaker and the Mississippi Chapter's scientific Assembly.

The AAFP requires that members complete a minimum of 150 hours of approved continuing education every three years to maintain membership.  $\Box$ 

# Dr. Waites Receives 1994 Physician Executive Award

Dr. James C. Waites of Laurel has been honored as the recipient 1994 Physician Executive Award. This award is given by the National Medical Group Management Association, American College of Medical Practice Executives honors Dr. Waites for his commitment and dedication to his profession and in recognition of his distinguished achievement and exceptional leadership in the health care field.

Dr. Waites is a charter member of the Practicing Physicians Advisory Council of the Health Care Financing Administration; chairman of the Physician Advisory Committee to the Medicare Fiscal Intermediary for the State of Mississippi; a member of the Medicaid Advisory Committee; chairman of the Mississippi Physicians' Care Network, sponsored

by the Mississippi State Medical Association; president of South Central Healthcare Inc., a physician hospital organization in the local hospital; a delegate to the American Medical Association House of Delegates; and councilor for the Southern Medical Association.

Dr. Waites, a UMC graduate, serves as a clinic supervisor through the University of Mississippi Medical Center and as a preceptor/mentor for physicians in training and nurse practitioner trainees. He

has worked with the local school system for more than 25 years as athletic team physician.

He has also served as president of the Guardian Society and the Medical Alumni Chapter of the University of Mississippi Alumni Association and as president of the MSMA.

A series of activities to honor Dr. Waites and this award will be held during the 68th Medical Group Management Association Annual Conference in October in Boston, Mass.



# Scott-Conner Appointed To USMLE Test Committee

Dr. Carol Scott-Conner, professor of Surgery at the University of Mississippi Medical Center, has been appointed to the United States Medical Licensing Examination (USMLE) step 2 Test Material Development committee for Surgery.

The examination committees for the USMLE program is composed of representatives of the academic, practice, and licensing communities.

USMLE, a joint program of the Federation of State Medical boards and the National Board of Medical Examiners (NBME), provides a common evaluation system for applicants for medical licensure in the United States.

Dr. Scott-Conner will serve concurrently as a member of the NBME Surgery Test Committee that develops the surgery subject tests.  $\square$ 

# New Board of Directors for The Mississippi Affiliate A HA

The American Heart Association - Mississippi Affiliate convened for the Annual Meeting, August 6, 1994. At the meeting a new volunteer Executive Committee/Board of Directors was installed. The physician board members for this year are: President-Elect Joseph Messina, MD - Grenada; Vice-President James Hays, MD - Jackson and Secretary John O'Connell, MD - Jackson.



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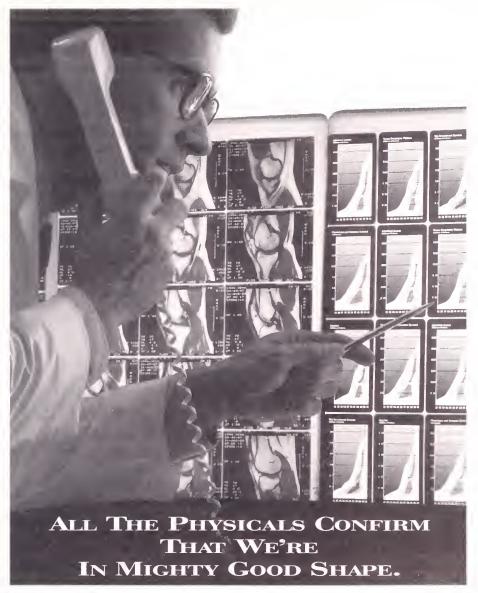
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# The University of Mississippi Medical Center

# Herring New ASB President

Joel Herring, a fourth-year medical student at the University of Mississippi Medical Center, has been elect the Associated Student Body (ASB) president for the 1994-1995 academic session.

Herring, a native of Hattiesburg, served as class president during h is first and second years at UMC. "I always like to be involved," he said.

The ASB is composed of elected representatives and designated officers from UMC's Schools of Medicine, Nursing Health Related professions, Dentistry, and the graduate programs in the medical sciences. Each school also selects its own student council.

As the official UMC student government organization, the ASB meets with and provides information and opinions on student concerns to the administration and faculty. The ASB also develops activities relating to academic programs and sponsors extracurricular activities.

One key factor in maintaining the original objectives of the ASB is to have good officers and administrative backing, Herring said.

Other ASB officers are fourthyear medical students Stacy Moulder of Brookhaven, vice president, third-year medical student Richard Arriola of Fulton, treasurer, and fourth-year health information management student Anne Thomas of Vossburg, secretary.

Moulder is the daughter of

James and Linda Moulder. Arriola is the son of Rodolfon and Daisy Arriola, and Thomas is the daughter of James and Sandra Thomas.

I'm excited to have their help. They've already done an excellent job," he said, "and I have the utmost confidence that we'll work well together."

The Medical Center recently underwent a change of command after Dr. Norman Nelson's retirement, as vice chancellor for health affairs and medical school dean, but his successor, Dr. A. Wallace Conerly, shares Dr. Nelson's views and will continue to meet with and assist the ASB in any way.

"Students must be top priority at the Medical Center; that's what we're about. Maintaining open and regular communications with the student body officers is a must so the administration can respond appropriately to students' expressed needs," Dr. Conerly said. "I really look forward to working closely with the student representatives."

Herring said he is pleased to know that the ASB is so strongly supported by the administration.

"The amount of exposure we have to the Medical Center CEO is one of the unique characteristics about being a student here. We can handle any problems before they get too big."

"That kind of involvement shows the administration and faculty are interested, and it allows the vice chancellor to be in touch with the students." Herring said. "I look forward to that continuing. I am definitely looking forward to getting to know Dr. Conerly and working with him."

A special fundraiser for a local charity is in the works, but no definite decisions have yet been made. Another project Herring is also particularly excited about is serving on the planning Committee for the new student union building, expected to be completed July 1, 1997. "I think the student union is going to be very useful for the students and for UMC in general—even though I won't be here to enjoy it."

Overall, with upcoming new projects and continuing traditional events, Herring anticipates that the academic year for the ASB will be a successful one.

"I want the ASB to serve the students in the full capacity as intended when it was established. I hope that we can continue to be a liaison between the students and the faculty, and that the different schools will work together individually and cooperatively," he said

"Personally, I want to make an effort to meet others in different schools as well as those in other classes. I want them to know I am available if needed."

"ASB Is sort of a support group for the students. It's not an easy task to get through a health professional ourriculum, but the ASB is here to do whatever we can to lighten the burden. We just want

JOURNAL MSMA

to make ourselves visible to let the students know that we are here."

Herring, the son of Dr. Emmett and Jeanne Herring, graduated from Mississippi State University and plans to specialize in ophthalmology. His brother, Dr. Lee Herring, is a 1992 UMC graduate.

# UMC Enrollment Increases

Enrollment for the 1994-95 academic session at the University of Mississippi Medical Center is 1792, 61 more than last year. The stu-

dent body this year also has the largest minority enrollment in the history of the Medical Center with 281, including 23 first-year medical students.

The School of Medicine has 389 enrolled; the School of Dentistry 121.

School of Nursing enrollment reached 382, 264 in the baccalaureate program, and 118 in the master's program.

The School of Health Related Professions has 347 students, including 21 in cytotechnology, 38 in clinical lab sciences, 36 in dental hygiene, 29 in health information management, 46 in occupational therapy, 141 in physical therapy, and 36 in emergency medical tech-

nology.

Graduate Students in the basic medical sciences total 96.

Certificate programs registered 39 in radiologic technology, and five in nuclear medicine.

Postgraduate students number 413, including 13 interns, 315 residents, 34 medical fellows, 27 postdoctoral fellows, 13 clinical psychology residents and 10 dental residents.

An additional 25 students will be registered in emergency medical technology at East Mississippi Community College next week. This will increase enrollment to 1817, with 1731 for the 1993-94 academic year.



OCTOBER 1994

# **Emergency Medicine Opportunities**

# Mississippi

Parkview Regional Med. Center

Vicksburg, Mississippi 231 Bed Facility

Annual ED Visits: 15,000

Needs: Director, full-time, part-time

Bolivar County Hospital

Cleveland, Mississippi 188 Bed Facility

Annual ED Visits: 14,500 Needs: full-time, part-time

BMH - Union County

New Albany, Mississippi 153 Bed Facility

Annual ED Visits: 19,000

Needs: Director, full-time, part-time

Gilmore Memorial Hospital

Amory, Mississippi 95 Bed Facility Annual ED Visits: 13,000

Needs: full-time, part-time

# Alabama

Jackson County Hospital

Scottsboro, Alabama 170 Bed Facility Annual ED Visits: 16,000 Needs: full-time, part-time

Clay County Hospital

Ashland, Alabama 116 Bed Facility Annual ED Visits: 6,000 Needs: part-time King's Daughters' Hospital

Yazoo City, Mississippi

88 Bed Facility

Annual ED Visits: 22,000 Needs: full-time, part-time

Montfort Jones Memorial Hospital

Kosciusko, Mississippi

76 Bed Facility Annual Ed Visits: 6,000

Needs: part-time

BMH - North Mississippi

Oxford, Mississippi 150 Bed Facility

Annual ED Visits: 15,000 Needs: full-time, part-time

BMH - Booneville

Booneville, Mississippi 121 Bed Facility

Annual ED Visits: 13,000 Needs: full-time, part-time

Russell Hospital

Alexander City, Alabama 100 Bed Facility Annual ED Visits: 12,000 Needs: full-time, part-time

Hartselle Medical Center

Hartselle, Alabama 90 Bed Facility Annual ED Visits: 8,000 - 10,000 Needs: part-time



Please Contact Donna Gutalj at: (800) 874-4053 For Further Informtaion

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# **New Members**

AHENE, CHARLES A., Jackson. Born Koforidua, Ghana, July 15, 1960; MD, University of Ghana, Accra, Ghana, July 1987; interned and 2 years of anesthesiology residency, Howard University Hospital, Washington, DC, 1990-93; one year anesthesiology residency, Cleveland Clinic Foundation, Cleveland, OH; elected by Central Medical Society.

FIELD, EDWARD D., Oxford. Born New Orleans, LA, July 30, 1958; MD, Tulane University School of Medicine, New Orleans, 1986; interned one year, Charity Hospital, New Orleans, LA, 1986; orthopedic residency, Tulane Medical Center, Childrens Hospital, New Orleans, LA, 1987, Hughston Sports Medicine Hospital, Columbus, GA, 1988, Huey P. Long Hospital, LA, 1988, Charity Hospital, VA Hospital, Tulane Hospital, New Orleans, LA, 1989; elected by North Mississippi Medical Society.

KAUFMAN, RICHARD J., Senatobia. Born Ohio, November 18, 1952; MD, American University of the Caribbean, Plymouth, Montserrat, 1981; surgery residency, Mt Carmel Mercy Hospital, Detroit, MI, Jan. 1982 - June 1987; elected by North Mississippi Medical Society.

PARKER, B. CLAY, Jackson. Born McComb, MS, April 8, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; interned one year University Medical Center, Jackson, MS; surgery residency, same, 1986-87; diagnostic radiology residency, same, 1987-91; fellowship in cardiovascular & interventional radiology, Alexandria Hospital, Alexandria, VA, 1991-92; elected by Central Medical Society.

PECUNIA, RICHARD A., Hattiesburg. Born Louisiana, January 2, 1959; MD, LSU School of Medicine, New Orleans, LA, 1986; general surgery residency, Allegheny General Hospital, Pittsburgh, PA, 1986-92; plastic surgery, University Medical Center, Jackson, MS, 1992-94; elected by South Mississippi Medical Society.

SHIRLEY, DEBORAH A., Starkville. Born Columbia, SC, July 28, 1952; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; pediatric residency University Medical Center, Jackson, MS, 1991-94; elected by Prairie Medical Society.

WEBB, JOHN H., Oxford. Born March 21, 1962; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; internal medicine residency, Vanderbilt University, Nashville, TN, 1989-92; gastroenterology fellowship, Medical University of South Carolina, Charleston, SC, 1992-94; elected by North Mississippi Medical Society.

WYATT, JOHN M., Gulfport. Born in California, January 15, 1945; MD, Ceux, Mexico, 1980; physical medicine & rehabilitation residency, Emory University, Atlanta, GA, 1986-89; elected by Coast Counties Medical Society.

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Mississippi Physicians Insurance Company is a Mississippi based corporation with a Mississippi based claims department. Our insureds receive personal attention with prompt, courteous service. We are always here for you whether by telephone or with a visit to your home town. MPIC's goal is to be a company you feel good about.

## A COMPANY WITH YOU IN MIND.

We offer more than an insurance policy. MPIC is the host of yearly regional workers' compensation seminars. These seminars are designed to inform you of your rights and responsibilities under the Workers' Compensation Act. Loss control consultants are also available for individual on-site visits. MPIC utilizes an active claims investigation staff. Fraudulent claims have been one of the highest costs in workers' compensation. When a claim appears questionable we find out the facts.

## A SPECIALIST IN THE FIELD.

Mississippi Physicians Insurance Company offers employers worker's compensation coverage exclusively. We focus all our efforts on how to "provide" workers' comp coverage rather than simply "writing it". We are the specialist in this field.

# **Personals**

James P. Almas has accepted the position of Medical Director for the Department of Pathology at St. Dominic-Jackson Memorial Hospital.

Brian Archer has associated with South Mississippi Emergency Physicians, P.A. in the practice of Emergency Medicine at Forrest General Hospital, Hattiesburg.

Dewitt Lamar Bolton of Picayune has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians.

John W. Bowlin of Tupelo has been accepted for membership by the American Association of Endocrine Surgeons.

Gloria J. Butler, a family physician, has joined the staff of the Vicksburg Clinic.

Charles D. Cannon, Jr. of Internal Medical Clinic of Laurel recently qualified as a certified medical review officer (MRO) by the Medical Review Officer Certification Council (MROCC). MROCC is an independent organization which conducts an extensive application process and examination to identify physicians with the skills necessary to evalu-

ate drug and alcohol tests in public and private sectors of the work place.

J. Ken Grafton, Jr., of Laurel has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

**Delores Hatcher** has joined the staff of the Vicksburg Clinic in general medicine.

Robert F. Heath has associated with Donald V. Conerly and Rodney N. Lovitt in the Petal Family Practice Clinic for the practice of Family Medicine.

Victor Horn of Houston has completed continuing medical education hours to retain active membership in the American Academy of Family Physicians.

Steve Mills a Brookhaven obstetrician-gynecologist will be the keynote speaker at the National Association of Junior Auxiliaries' area meetings in Jackson, MS; Memphis, TN and Little Rock, AR. He will speak on the topic, Living In The Danger Zone, which concerns the life styles of today's teens.

W. Ray Reed of Tupelo was certified by the American Board of Radiology in June. He is also coauthor of an article titled, *Implications of the Anemia of Chronic Disorders in Patients Anticipating Radiotherapy*, published in the Journal of Medical Sciences, July 1994, 308, no. 1.

Ben Sanford and J. Scott Ferguson of Starkville Internal Medicine Clinic announce their merger and association with Internal Medicine Associates Foundation, Inc. of Corinth, Tupelo and West Point.

David R. Segrest of Jackson is a 1994 Honor Award Recipient of the American Academy of Ophthalmology. Honor awards recognize individuals who have made a significant contribution to ophthalmology through presentations at the Academy annual meeting, and for service on Academy committees.

The *Journal MSMA Personals* Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage you to send notices to: Personals Column Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 354-4834.

# Physicians' Recognition Award

I I

Seven MSMA members were named recipients of the AMA Physicians Recognition Award in July and August. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

NORTH MISSISSIPPI MEDICAL SOCIETY

John P. McLaurin, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY
Patrick Sung Lung Hsu, MD
Robert Phillips Mathis, MD

Prairie Medical Medical Society Thomas J. Cobb, MD Thomas Hosmer Price, MD

South Mississippi Medical Society David Ira Hirsch, MD

WEST MISSISSIPPI MEDICAL SOCIETY Chester W. Masterson, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases) and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1.3

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.  $^{1,3,4}$  1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to  $\frac{1}{2}$  tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.  $^3$ 

How Supplied: Oral tablets of Yocon\* 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

- 1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188.
   McMillan December Rev. 1/85.
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## **Dateline**

## Journal of the Mississippi State Medical Association Volume XXXV, Number 11

Credit card-like device can hold a lifetime's worth of medical records

Meridian, MS — A Mississippi-designed portable personal health file may modernize medical record keeping. Or as the motto of the cardmakers stress: "The people's card: Don't leave your health without it."

Two Meridian physicians and an engineer have developed and patented a card they say will hold the medical records of an individual for a lifetime.

"It will enhance and increase the accuracy of medical record keeping and enhance the availability of the medical profession to diagnose and treat the patient," said Dr. James Purdy, an obstetrician and gynecologist at Rush Medical Group in Meridian.

Dr. Purdy is chief executive officer and president of HealthSafe Systems, a division of Medical Records Technology, PRG, Inc. of Meridian. Dr. James Gleaves, a general surgeon, is vice president and Randy Guttery is systems engineer.

The device, which looks like a credit card, is officially called the "Technology Optical Card." The card will be piloted at Rush Foundation Hospital, the hospital emergency room and the clinic in 30 to 45 days. Representatives from Rush Medical Group, the state Department of Health and the Canon Co. were on hand to lend their support.

Dr. Purdy and his partners don't know how much the card will cost. The medical card, which is inserted into a Macintosh computer, can hold up to 1,300 pictures and 2,400 to 3,000 pages of data. Dr. Purdy and his associates are working with New York-based Canon Optical Card system, which provides the cards and a reader/writer computer for the card.

Once the card is inserted into the Macintosh system, a picture of the patient comes up within seconds, followed by a medical history, including any surgery, physician visits and prescriptions.

Dr. Purdy and his two partners have been working on the system for more than five years.

Randy Guttery said their system has been tested by the best computer engineers and so far has survived. "It is impervious to viruses and if the system cuts off as a result of a storm or electrical problem, data isn't lost," he said. A persons medical record can be updated by inserting the card into a compatible system, and the information can be sent to other compatible systems in a matter of seconds.

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MSMA Health Issues Seminar & Legislative Forum January 17, 1995

## **CME Opportunities**

## Delta Region AIDS Education and Training Center

#### 5TH ANNUAL NEW ORLEANS HIV/AIDS UPDATE FOR THE PRIMARY CARE PROVIDER

Prevention • Treatment • Survival Helping to Put the Pieces Together

May 1-3, 1995

(during the Jazz Festival)
Sheraton Hotel
500 Canal Street
New Orleans, Louisiana
1-800-253-6156

The health care provider conference referenced above is sponsored by the Delta Region AIDS Education and Training Center, LSU Medical Center Schools of Medicine and Nursing, Tulane University Medical Center and Alton Ochsner Medical Foundation, and is endorsed by New Orleans Nurses for AIDS Care (NONAC).

Conference fees include three days of lectures and workshops, all course materials, continental breakfast every day, one luncheon, and refreshments. Physicians \$250; NPs, PAs, Nurses, Others \$150; Residents, Medical Students and Nursing students \$50.

For more information about the conference, contact Chip Lohner at 504-568-3855.

MSMA 127th
Annual Session
May 17-21, 1995
Treasure Bay Resort &
Casino
Biloxi, MS

#### **Tulane University Medical Center**

Course: Otolaryngology Update for Pediatricians

Date: January 28, 1995

Location: Westin Canal Place Hotel New Orleans, Louisiana

Sponsor: Tulane University Medical Center Department of

Otolaryngology and Office of Continuing Education

Director: Donald Cote, MD

Cost: TBA Credit: TBA

Specialty: Pediatrics, Family Practice
Contact: Office of Continuing Education
(504) 588-5466 or 1-800-588-5300

Course: "Neuropsychiatric Aspects of Primary Care"
Date: February 17-19, 1995 (Mardi Gras Season)
Location: Le Pavillon Hotel, Poydras and Baronne

New Orleans, Louisiana 70140

(800) 535-9095

Sponsor: Tulane University Medical Center Department of Psychiatry

and Neurology and the Office of Continuing Education

Credit: 10.5 credit hours, Category 1
Director: Dr. Paul Rodenhauser

Cost: \$250.00

Specialty: Family Practice, General Practice, Internal Medicine, Emer-

gency Medicine

Contact: Tulane Office of Continuing Education, Pamala A. Schmidt

(504) 588-5466 or 1-800-588-5300

Course: "Incontinence Update 1995" Urogynecology & Urodynamics

Interactive Seminar and Workshop

Date: February 24-25, 1995

Location: Hyatt Regency

New Orleans, Louisiana

Sponsor: Tulane University School of Medicine Department of Urology,

Nursing Resource Center and Office of Continuing Medical

Education

Director: Gamal M. Ghoniem, MD

Cost: Physicians: \$400 (by 1/24/95) \$450 (after 1/24/95)

Residents\*: \$325 (by 1/24/95 \$375 (after 1/24/95)

(\* with letter of verification)

Credit: TBA

Specialty: Urology, OB/GYN, Internal Medicine, Family Practice, General

Practice, Nursing, Allied Health, Physician Assistants

Contact: Tulane Office of Continuing Education

(504) 588-5466 or 1-800-588-5300

(Continued page 346)

## Original Article

## Laser Treatment for Snoring

S. H. LAMBDIN, M. D., F.A.C.S.

CO<sub>2</sub> Laser Assisted Uvulopalatoplasty (LAUP) is a safe and effective, ambulatory treatment for snoring, performed under local anesthesia. By means of multiple sessions, the LAUP progressively enlarges the airspace of the oropharynx, reducing the bulk of the vibrating soft palate and wide posterior tonsil pillars. Advantages are that it is simple, reliable, painless, bloodless and outpatient. Disadvantages are the multiple sessions, the high teclinical effort, and Laser costs.<sup>1</sup>

Onoring is an obnoxious noise, and it can be a serious problem when the sleep of friends and family is compromised. It is well known that snoring, and the resultant sleep deprivation for the spouse, can lead to spousal problems with depression, mood alteration and marital discord. Moreover, snoring can be medically hazardous to the patient. Patient problems with insomnia, sleep apnea, irritability, poor short term memory, depression, fatigue, headaches, daytime somnolence, and sexual dysfunction are well documented.2,3 Only in recent years have researchers discovered between snoring, or hypnogenic stenosis of the airway, and other medical problems. These problems are derived from the related airway obstruction and associated hypoxia sustained dur-

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ing sleep in snoring/apnea patients. Buda and co-workers have shown that maximum airway efforts against a closed airway impedes left ventricular function.4 As the patient works against the stenosed airway, physical labor is heightened in an attempt to ventilate the lungs. Lugaresi et al. demonstrated that with snoring, alveolar ventilation and thus blood oxygen saturation decreases.2 In an attempt to compensate, negative intrathoracic pressure increases dramatically during snoring, and apnea in particular. After years of nocturnal hypoxemia and left ventricular strain, chronic hypertension can result, the statistical correlation demonstrated by Lugaresi, et al. Lugaresi et al. also have shown that snoring increases the negative pressure in the esophagus as well, increasing the incidence of reflux, gastroesophagitis, and aspiration bronchitis.5 Often the object of ridicule because of their snoring, patients are reluctant to initiate a discussion on the matter. However, with an estimated 21 million Americans experiencing clinically significant snoring/apnea, we physicians should probe for it more often, especially in those with the above mentioned medical problems.

#### **MANAGEMENT**

Conservative therapy includes recommendations for weight loss, daily exercise, positioning, avoidance of CNS depressants (ETOH, sedatives, etc.), various palate/tongue splints, and CPAP. For those who have failed conservative therapy, surgery can be considered based on the primary anatomic site of stenosis, ranging from a T & A to a tracheostomy for extreme Obstructive Sleep Apnea Syndrome (OSAS). In the majority of cases, the of-

sue of the soft palate and posterior tonsil pillars, which, prior to the LAUP, was best managed by a Uvulopalatopharyngoplasty (UPPP). The UPPP however, is was quite painful, required general anesthesia and several days of hospitalization. There is also the risk of excessive palate resection with this one stage procedure. Where the scalpel is able to produce only one action, cutting; and electrosurgical instruments can cut and coagulate; the laser adds a third ability—it can cut, coagulate and vaporize tissue. The tissue effects of the CO, laser energy in the wounds of the palate contribute to the success of the LAUP and to the patients' tolerance of the procedure. In the CO, laser wound, there is a center area of ablation with a few carbon flakes. Surrounding this is an area of protein denaturation approximately 50 microns in diameter, in which small vessels, nerves, and lymphatics are "sealed." Next is an area of tissue edema about 250 microns. which remains viable tissue. The minimal mechanical trauma and the "sealed" area probably account for the notable absence of postoperative edema and pain in laser wounds, and in the LAUP in this instance. Also, Norris and Mullarkey have shown collagen formation to be much slower in laser wounds 6, thus allowing for multiple procedures on the palate with minimal fibrosis. The LAUP is indicated for grade 2-3 snorers, with minimal to mild apnea, with a normal head and neck exam excluding the palate and tonsillar pillar region. Fiberoptic evaluation of the airway to confirm the region of stenosis and pre-operative polysomnography in suspected apnea patients are advised.

fending area is the vibrating tis-

#### **TECHNIQUE**

The patient is placed in the sitting position, and the palate topicalized with 10% Xylocaine, then locally infiltrated with 2 or 3 1 cc injections of 2% Xylocaine with epinephrine. The CO, Laser, with the oropharyngeal handpiece and backstop, set on 15 20 watts CW Continuous, is used to cut a 1 cm vertical trench through and through the palate on each side of the uvula. Next, with the Laser in defocus or Swiftlase (TM of Sharplan Lasers) mode, the newly created "uvula" is reduced in bulk by 50%. The Laser vaporization can be extended to the tonsils directly if they are significantly hypertrophied. Bleeding is rarely a problem and pain is usually managed by mild analgesics. The patient can most often return to work in an hour. Sessions take 10-15 minutes and are usually spaced 4 weeks apart, females requiring 3-5 sessions, males 4-7.

#### RESULTS

Patients are highly compliant as they are quite motivated in most cases. Their endpoint is reached when they have stopped snoring or all vibrating tissue has been removed. Snoring is improved not only by removing vibrating tissue bulk, but also by the palate gradually retracting in an anterior-superior direction, thus enlarging the oropharyngeal airway. Studies have shown the LAUP to eliminate snoring in 85% of patients, improve snoring 12%, and to be of no benefit in 3%.1

#### CONCLUSION

- Snoring and sleep patients have many concomitant medical problems.
- 2. The LAUP is a safe, effec-

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tive procedure for certain snoring/apnea patients in an office/outpatient setting. 

204 Eighth Street Greenwood, MS 38930

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- Dr. Lambdin, whose specialty is Surgery, is in private Practice in Otolaryngology-Head and Neck, Greenwood, Mississippi.



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# Are PSA 8-10 Particularly Worrisome Numbers?

JOHN P. ELLIOTT, JR., MD JAMES O. GORDON, MD JOHN W. EVANS, MD LUCAS O. PLATT, MD WM. HUGHES MILAM, MD JOEL R. RIGBY, MD

etween April, 1989 and August, 1992, seven hundred eighty-eight transrectal ultrasounds were performed by a sixman office based urology group (an average of about one TRUS per urologist per week.) Six hundred ninety-seven of these had transrectal prostate biopsies. Early on, TRUS was performed without biopsy if no hypoechogenic lesion was seen. As it became apparent that carcinoma of the prostate is not always "typically hypoechogenic", a more lenient criteria was adopted to include any displacement of the peripheral-transition zone borders or any area that the physician felt questionable. If the PSA was abnormal, then four to six quadrant

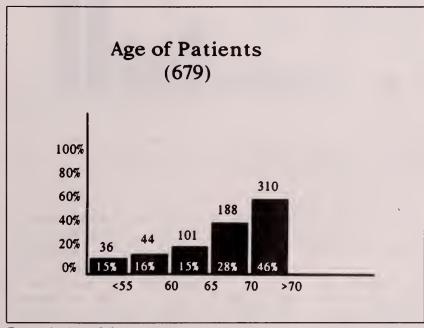


Figure 1: Age of the patients.

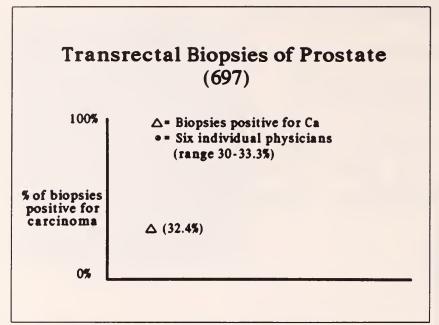


Figure 2: Percentage of total biopsies positive for cancer of the prostate.

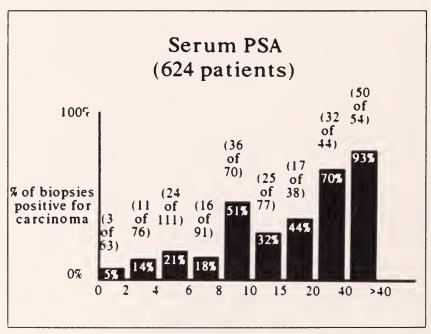


Figure 3: Percentage of biopsies positive for carcinoma of the prostate correlated with PSA level.

biopsies were frequently taken, even in the absence of overtly suspicious lesions.

#### **METHODS**

The routine evaluation of the male urology patients in this clinic includes digital rectal examination and prostate specific antigen. If either one of these tests are abnormal, we proceed according to the recommendations of Cooner and others (1,3,5,7,8) and evaluate the prostate by transrectal ultrasound with probable biopsy. All of these procedures are done in the office.

Preparation includes a Fleets enema and an oral antibiotic one hour prior to the biopsy followed by a repeat dose of the antibiotic later in the day. All patients are off aspirin for five days prior to biopsy.

No "screening for carcinoma of the prostate" TRUSs (2,3,4,6) were done in the absence of either an abnormal digital rectal examination or serum PSA of >4.

#### **RESULTS**

The age of the patients revealed that about half were over seventy (Fig. 1).

The average percentage of positive biopsies was 32.4% positive for carcinoma of the prostate. (Fig. 2) The range for the six physicians was 30-33.3%.

An analysis of PSAs in six hundred twenty-four patients ranged from 5% positive in the 0-2 PSAs to 93% positive in the PSAs over 50 (Fig. 3). There was a spurious finding of 50% positive in the PSA range 8-10, whereas the 6-8 PSA category showed only 18% positive and the 10-15 PSA category showed only 32% positive.

Analysis of 132 patients that were referred for an abnormal digital rectal exam (DRE) showed that if the PSA was above 4, 58% were positive for carcinoma of the prostate. If the PSA was below 4, only 15% were positive. (Fig. 4) If the patient was referred to the urologist because of an abnormal PSA (greater than 4) and the digital rectal examination was suspicious or equivocal, then 60% were positive. (9) If the digital rectal exam was not suspicious, in spite of the PSA elevation above 4, only 27% were positive. Fig. 5

#### COMPLICATIONS

One elderly patient was hospitalized overnight for observation for

### Patient Referred to Urologist for Suspicious Digital Rectal Exam (DRE) 132 Patients

Abnormal PSA (>4) Normal PSA (<4) % Biopsies Positive58% (49 of 84)15% (6 of 41)

Figure 4: Patients referred for suspicious DRE.

## Patient Referred to Urologist for Abnormal PSA (>4) 189 patients

A. DRE is suspicious

B. DRE equivocal

C. DRE is not suspicious

% Biopsies Positive

61% (50 of 82)

56% (5 of 9)

27% (26 of 98)

Figure 5: Patients referred for abnormal PSA.

mild continued urinary bleeding. One patient was seen in the E.R. for moderate perirectal hematoma the day of his biopsy. No patient was hospitalized for fever or U.T.I..

#### DISCUSSION

The spurious elevation of the PSA category of 8-10, if confirmed on other studies, might mean that a PSA of 10 to 15 is frequently infection, and a PSA of under 8 is frequently BPH. This information might give the urologist a higher index of suspicion prior to the TRUS.

#### **CONCLUSIONS**

The conclusion - PSA level of 8-10 may be a particularly trouble-some number. The possible explanation could be that PSA from infection is usually greater than 10 and PSA from BPH is usually less than 8.

We further conclude that using the Cooner criteria of either an abnormal PSA or DRE prior to TRUS results in a high yield of cancer diagnosis (32%) without over utilization of the technology (one TRUS/urologist/week). Outpatient TRUS with prostate biopsy is a safe procedure.

605 Garfield Street Tupelo, MS 38801

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Drs. Elliott, Gordon, Evans, Platt, Milam and Rigby are in the private practice of Urology with the Urology Professional Association, Tupelo, MS.

# Are You Sorry You Went To Medical School?

CAROLYN T. GERALD, MD, FACEP

Ve sat bleary-eyed sipping strong coffee at the hectic Emergency Room desk changing shift early one morning recently. Our conversation was continually interrupted by the belligerent shouts of an intoxicated M. V. A. patient and the never-ending "beepbeep-beep-beep" radio signals from paramedics reporting incoming ambulance arrivals. My E. R. Doctor buddy pressed his weary eyes with his thumb and forefinger a moment then looked at me quizzically, "Carolyn, if you had it to do over again, would you still do this?" "Are you sorry you went to Medical School?" I didn't answer. We both laughed softly, shook our heads, and went on with the report so he could go home to sleep and I could go see about the E. R. patients who had become my charges until the next shift change.

Like many of my colleagues, I've grown bitter and disillusioned at times with medical practice after years of bombardment by government bureaucracy, accelerating insurance regulations, pressures from PHOs, HMOs and ever mounting paper work. The spectre of malpractice has even made me afraid of some of my patients. Overworked and overwhelmed, I often wonder why in the world I ever struggled so long and so hard to be a "Doctor". When I ask myself, "If I had it to do over again, would I do it?", sometimes I sit and wonder sadly what my life would be like if I'd taken a different turn in the road. I have altered my medical practice to bend without breaking as I've grown older. After ten years as a rural General Practitioner who also moonlighted heavily in the Emergency Room, I made the difficult decision to give up my private practice. I've kept my E. R. work though and am proud to report that I even passed my E. R. Boards. I also work part-time in a University Student Health Clinic

which is easy fun and uplifting. I no longer have to worry about being "on-call". Even with these changes, life as a practicing physician remains unbelievably stressful. Problem patients are everywhere.

At the University Student Health Clinic not long ago, I was summoned by a harried nurse who informed me about a situation with a frequent visiting patient who is known to the staff as a "drugseeker". Having been denied narcotic prescriptions after a careful medical evaluation by another physician who'd left for the day, the patient had returned unexpectedly, walked back to our observation unit, laid down on one of our beds, folded his arms across his chest, and proclaimed with loud hostility, "I'm not leaving here until 1 get something for pain!" It was one of many tense unhappy moments all physicians are familiar with and face on an all too regular basis. After intensive reasoning with the patient, much discussion involving the patient's family and even having to call the University Security Personnel to stand by, it was finally resolved......temporarily. (He'll be back.)

Another morning this year I sat yawning and drinking early morning coffee with another Medical buddy. We were still "Doctors" but functioning in a different role today as we sat in the House of Delegates at the Mississippi State Medical Association Annual Meeting. The morning agenda had been long, boring, and busy and we were ready for a break. "If there's any one job at this meeting that I would really like to have had, it was afforded to me when the speaker in divvying up our responsibilities asked me to make the next introduction." Dr. George McGee, a young surgeon and an old friend was at the podium introducing Dr. Robert E. McAfee, the President-Elect of the American Medical Association. "Oh, great, George", I thought to myself, "that's all we need." "Another long-winded national official who don't know nothing about real medicine." The eloquent introduction went on and we all stood and applauded to show proper respect....then Dr. McAfee began to speak.

He took us by surprise. He was funny. He was charming, warm sincere and gracious. Most important of all, he was real and he did indeed know something about real medicine. The audience woke up, galvanized by this talented public speaker...with just the right balance of wit and articulate knowledge...sizing up and summarizing problems and serious concerns facing us today. "It makes me sad", he was saying,"to hear one of us say, "I would no longer advise or encourage my son or daughter to become a Doctor

in this day and age." "He went on to talk of many things but this quote from his awe inspiring speech struck deep into my heart and brought tears to every eye in the room. With Dr. McAfee's gracious permission, I share it with you. "The real reason each and every physician is in this room today is not because of a health care plan, it's not because necessarily, of joining the Mississippi State Medical Association...it's because more importantly, many years ago, you made a decision what you wanted to do with your life....and you did it..by becoming a Doctor." He talked on and then he asked each of us to do him a favor. "When you go to your office tomorrow, ask your girl to hold your calls for a few minutes, go in where your medical school diploma is." "Take it off the wall and, if it's anything like mine..dust it off." "Hold it in your hands, shut your eyes and think back to the very moment that you were given that tangible expression of what up to that point probably was the most significant accomplishment in your life." "Perhaps one participated in with your spouse, your family...others assisted you in getting to that point...but YOU did it." "And at that point you had available to you the most immense freedoms to do with your life...more than any other individual, any other profession has on the face of this Earth." "You could be a teacher, you could be an administrator, you could be a researcher, you could be a clinician...as most of us did and could practice wherever you wished to, in whatever kind of arrangement you wanted to on any place on the face of the Earth." "And if you went into surgery as I did and George and others ....think back to that Friday night...that first Friday night special...in which you were called

in." "That 19 year old multiple injured auto accident...multiple long bone fractures, head injury - but the dominant injury was the abdomen which was expanding before your eyes because of massive bleeding." "The patient had a barely perceptible Blood Pressure...wasn't going to make it if something dramatic didn't happen." "And you whisked him to the operating room and opened that unprepared abdomen and you saw more blood than you'd ever seen before in your life." "And you hoped beyond hope it was that simple spleen...and as you ran your hand in the left upper quadrant and separated that large clot, you could feel the stellate fracture on the capsule of that spleen and you knew that that was the injury." "And as you carefully ran your hand down around the splenic pedicle and pushed the tail of the pancreas away with your little finger and squeezed as you encircled the splenic artery and vein together...and could barely feel that feebly perceptible pulse and squeezed your finger." "And you hoped...maybe you prayed a little bit..and as you felt and as you held on, you could began to feel the amplitude of that pulse getting stronger...as you see at the head of the table the anesthesiologist is beginning to get a pulse, a pressure.....and you KNOW at that minute...that 19 year old was going to live 50 more years... because of what you're doing at that moment." "Ladies and Gentlemen, that's the single greatest natural high that one individual can feel for another on the face of the Earth." "And it's not unique to surgery." "If you went into primary care, pediatrics, family practice...think back for the very first time that that 1 1/2 ... 2 year old with his very first attack of asthmatic bronchitis is rushed to the Emergency Ward by very

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young parents...perhaps too young by some standards." "And as you examine this child who looks terrible...he's ashen, grey, he's using every accessory muscle of respiration...doesn't look like he's going to take another breath, you look up at the faces of these young parents who have never thought of death before." "There are tears in their eyes." "There are tears of pleading for you." "Do something for our only child." "And, fortunately, it's easy saved... the bronchospasm can be relieved with bronchodilators and the cool mist and the oxygen and within a very few minutes, the child pinks up... the respirations slow and he drifts off to sleep." "And you all three look back at him again...and you all know he's going to be O. K." "And you look back in the faces again of those parents." "The tears are there, but they're different tears." "If there is such a thing as tears of joy and tears of love....for YOU....because you're a Doctor." "You know there isn't

any CPT for that." "There isn't any relative value that anybody's ever going to put and I hope there never is." "And, you know, in obstetrics the same thing occurs." "That sum total of your entire training comes to those few terrifying moments when two lives are on the line." "You've got to do the right thing...and you do it...and from that point on...that baby is always referred to as my daughter, Susan, who wouldn't be here if it wasn't for Doctor Johnson." The soft powerful magic of his words flowed on a while longer. A breath-holding quiet gripped the audience. Each of us could hear their own heart beat as we did look back and think back sweeping away the insignificant cobwebs of our life stresses. Of course, we still wanted to be a Doctor. How could we have misplaced these deeply important feelings....let them be squashed down by an army of petty aggravations?

I can't speak for everyone

lucky enough to be present in that room that day, but I know my priorities were re-set. Sure, I still get frustrated angry, perplexed, worried, tired, and overwhelmed. The stress of medical practice hasn't suddenly disappeared. But, now, I have no hesitation in answering that question. That question - "Carolyn, if you had it to do over again, would you still do this?" "Are you sorry you went to Medical School?" "Yes, I would still do this....and, NO, I'm not sorry I went to Medical School." I thank God for the privilege of having a chance to experience those rare sweet natural highs. Just one or two of those in a lifetime make the strenuous battle worthwhile.

Dr. Gerald is an emergency physician who also works at the USM Student Health Clinic in Hattiesburg. In her spare time she is a freelance writer.

The Journal of the Mississippi State Medical Association welcomes material for review and publication.

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The President's Page MALLAN G. MORGAN, MD

#### **RIPPLE**

No, I'm not referring to my favorite wine, as some wag may insist.

Today I'm thinking about our effect on the people with whom we come In contact on a daily basis, personally and professionally. Like a pebble in a pond, the ripples of our influence spread way beyond our homes, offices, and our patient's hospital rooms. It's not just the immediate effect of removing the gallbladder, casting the fractured radius, or giving thrombolytics to reverse a myocardial infarction. There are many ripples. (more profound effects) on our lives, and those of others with which we come in contact, than the simply physical results of our treatments. I'm not talking about our "image" as I did last month, but our effect on people. Maybe the ripple of our existence could also be referred to as "relationships".

I'm talking about how we treat (and I don't mean medically) our patients and their families. You and I have gone into a room and have had to tell a patient and his/her family that the disease is fatal. Or, wondrously, that their loved one for whom we held little hope is better and, with God's help, will make it through the night, and beyond. Handling these situations in a compassionate, humane and feeling manner is indeed good for our "Image", but let's look beyond that. Whatever the situation, what we do, say and otherwise convey to our patients and their families in a crisis situation is something that they will live with for the rest of their lives.

What we say, how we may it and how we act--but most importantly-that sense of sincerity and caring that we convey to our patients will not only be felt by them, but also by their parents, their children, their grandchildren and their friends. We have the power and the privilege to be present in some of mankind's most traumatic (or most joyful) moments. I implore you to make these moments as gentle and meaningful as possible to those we serve. I assure you that the "Ripple" of your

(Continued on page 332)

### **Editorials**

JOURNALOFTHE MISSISSIPPISTATE MEDICALASSOCIATION VOLUME XXXV, NUMBER 11 NOVEMBER 1994

#### THE IRON GATE

I remember the days of training and the medicine resident on call to the ER and how I, as an intern, looked up to him. He was the keeper of the gate, nervelessly discharging chest pain patients I had agonized over, absently flicking the ashes from his cigarette as he jotted a few words beneath my report. Harried, exhausted interns would bestow the equivalent of the Medal of Honor on him in their praise.

We've all since grown out of that. One story from a cardiologist of how as a moonlighting fellow he resuscitated a patient in the ER parking lot, a patient he had discharged only minutes before, did wonders for my perspective. Long ago I could tell with great precision the source of any chest pain. Give me five minutes with the patient—the character of the pain, the manner in which he pointed to his chest, the slight hesitation over a word—and I could tell. Now I am older and not so sure. I admit patients these days that would have set the interns smirking at each other with careful sidelong looks.

I am a general internist, just the sort of fellow the managed care barons are looking for. But regardless of what some may think, virtually no one practicing primary care relishes the idea of being a gatekeeper. Deny patients what they want? Treat them when they would prefer another doctor? This isn't what we suited up for. The worst moment in my day is getting a request for home health services from a Medicare patient I know doesn't qualify. I can say yes to everyone and have the phone lines to my small office white hot with visiting nurses calling to report a patient's constipation, or I can say no and face the rancor.

Yet last week I agreed to be a gatekeeper. What led to this moment of weakness? Well, she really was very nice, patient almost to a fault, quite aware that the product she had to sell was not off the shelf of a boutique. I might have heard, she said, of a Medicaid demonstration project up in the Delta placing patients under a case manager primary care physician. I supposed to her that I had. She went on. Medicaid is hemorrhaging financially trying to pay the bills of patients who doctor-hop or who go to the emergency room for non-emergencies. States trying the system have saved vast sums of money. Since the trial seemed to be going well the project was being extended to Jefferson County to our north.

So I said yes. Worried that many calls from patients would break the back of my already busy office, I told her I would take but a few at first and build as we adjusted to the load. I'm also a bit concerned about what exactly constitutes an emergency at the ER and what can come over to my office. But I also know that only the doctors can

(Continued on page 332)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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presence, your words, and your actions goes way beyond that patient's room. It also goes on to the friends and family who are even thousands of miles away, and to all who are involved with your patient for years to come.

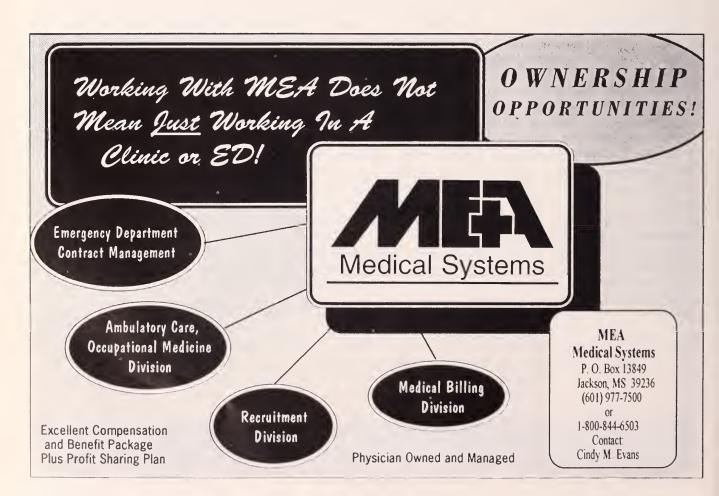
So I ask you to please remember the ripples of your relationships with your patients, as well as your personal relationships, as they do spread in ever widening circles.

Mal

save Mississippi's Medicaid system. The patients certainly can't, and the legislature seems to be throwing all the money it can at the situation. I don't want to gatekeep for some large insurance company, to work as hired labor so that at the board meeting someone can rise to announce that profits are up this year a full 9.2% and then the bottle be passed and toasts made and the whispering start as to whose career should take off now.

Perhaps the money Medicaid saves by using case managers never will come back to the doctors as higher fees. Maybe it will be used to cover more people, but that's fine, too.

Leslie E. England, MD Associate Editor



## **LETTERS**

To The Editor, Journal MSMA.

#### Dear Sir:

I appreciate the opportunity to respond to Dr. Carter's comments regarding my article, Fine Needle Aspiration of Parotid Masses, which was recently published in the Mississippi State Medical Association Journal.

While the diagnosis of salivary gland lesion is challenging, it is not difficult given a good technical aspirate and an experienced pathologist. The sensitivity or positive diagnosis in the presence of tumor was 92% in the reported series. I think that most would agree that a test with a 92% accuracy rate is helpful indeed. Even in experienced hands there is a real risk to the facial nerve when performing parotidectomy (probably 5% or less). I am unaware of any cases of fine needle aspiration (FNA) damaging the facial nerve, nor are there any reports in the literature documenting this type injury. Importantly, there have been no cases of tumor implantation along the needle tract from any head and neck site. Morbidity also deserves special mention. There is a significant amount of morbidity following a surgical procedure such as parotidectomy. The morbidity of FNA is essentially that of a venipuncture.

The cost of parotidectomy in Dr. Carter's hospital is \$3450.00. This figure does not include surgical and anesthesia fees. Anyway you look at it \$3450.00 (plus surgery and anesthesia fees) does not compare favorably with the cost of \$100.00 for FNA.

The mere presence of a lump, without adequate pre-operative evaluation, no longer dictates its removal. FNA allows an accurate diagnosis and a more complete treatment plan to be formulated. Fine needle aspiration has proved its value in other areas of clinical medicine as well. Some examples include fine needle aspiration of the thyroid, breast, prostate, lung, and liver to mention only a few.

C. Ron Cannon, MD

Jackson

LETTERS, COMMENTS or QUERIES... The Editors of *The Journal MSMA* invite members of the MSMA and others to comment for publication on any material that appears in the publication or on other current medical issues. If you have a letter, comment or query, please send it to: The Editors *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229. The views expressed in this section are those of the indicated author and are not expressions of the views, or officical policies of The MSMA.

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## **Medical Assurance Company of Mississippi**

Medical Assurance Company staff and legal counsel have been studying recent decisions of the Mississippi Supreme Court, and the negative impact they have had on the practice of medicine is alarming.

It has become abundantly clear that the medical profession -- indeed, practically all defendants in civil matters -- are no longer playing on a level field where the Supreme Court is concerned.

The chart below illustrates medical malpractice decisions of the Supreme Court since 1989. Of cases heard prior to 1989, the patient prevailed in 50% and the physician or other health care provider prevailed in 50%. Since 1989, however, those numbers have changed to 76% for the patient and 24% for the health care provider.

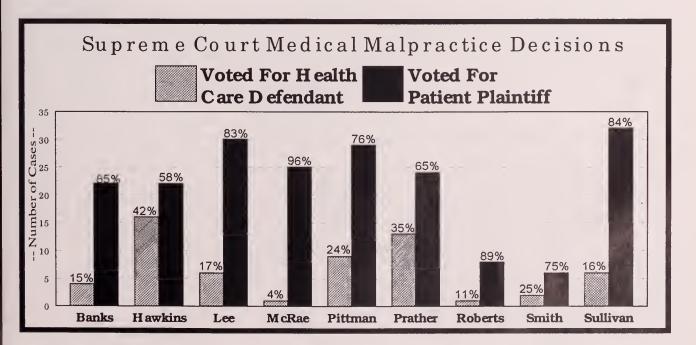
The time has come for the medical profession to get involved in judicial elections, particularly at Supreme Court and Appellate Court levels. We cannot sit idly by and watch the plaintiff bar "invest" in justices who will protect their special interests.

Unfortunately, Justice McRae (a former plaintiff attorney with a record of voting against health care

providers in 94% of the cases he has heard) was unopposed in the November 8, 1994 election -- so we are stuck with him for another eight years.

All of the justices are listed below, along with the date their terms end. We plan to watch closely those up for re-election in 1996, and we will keep you apprised of their voting record through the MACM Monitor and the MSMA Journal.

Mississippi Supreme Court			
Judge	Term Ends	Date of Election	
Lee (Dist 1 No 1)	1/1998	1996	
Banks (Dist 1 No 2)	1/1997	1996	
Smith (Dist 1 No 3)	1/2001	2000	
McRae (Dist 2 No 1)	1/1996	1994	
Sullivan (Dist 2 No 2)	1/2001	2000	
Pittman (Dist 2 No 3)	1/1997	1996	
Roberts (Dist 3 No 1)	1/2001	2000	
Prather (Dist 3 No 2)	1/2001	2000	
Hawkins (Dist 3 No 3)	1/1997	1996	



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## Mississippi Foundation For Medical Care

Awards and recognition have highlighted recent weeks for the Mississippi Foundation for Medical Care. Dr. James S. McIlwain, medical director, Fred A. Parish, executive director, and Dr. Alton B. Cobb, principal clinical coordinator, came back from national meetings with awards.

#### AMPRA DIRECTOR

Dr. McIlwain, who has been recertified as a Diplomate by the American Board of Family Practice through 2001, also won an election at the September American Medical Peer Review Association annual meeting held in Kansas City, MO. AMPRA, the national membership association, includes the network of state-based independent peer review/quality improvement organizations. Dr. McIlwain was elected to the board of directors for AMPRA representing Region II. Some 14 states are represented in the region.

#### RECOGNITION

Fred Parish, executive director since 1984, was honored at the Kansas City meeting "in recognition and appreciation of ten consecutive years of services as an AMPRA member." He joined MFMC in 1974 as a field representative.

#### CONTRIBUTIONS

Dr. Cobb, principal clinical coordinator for nearly two years, has been recognized for his contributions to the improved health of women and children in Mississippi during his tenure as director of the State Health Department. The award was presented to him at the meeting of Region VII of the Academy of Obstetrics and Gynecology in Montreal, Canada. As clinical coordinator at MFMC, he is in charge of cooperative projects with physicians and hospitals to improve the overall quality of care for Medicare beneficiaries in Mississippi.

## SPECIAL QUALITY IMPROVEMENT AWARD

The Board of Directors has announced the establishment of the annual MFMC Quality Improvement Award.

Recognition will be given to the provider chosen for submitting the best quality improvement project which demonstrates principles of continuous quality improvement. The award will be presented at the MFMC Annual Meeting which is associated with the Mississippi State Medical Association annual sessions. Recognition will be through publications and the presentation of a certificate and trophy for the best submitted improvement project.

For more information, contact Dr. James McIlwain, medical director at MFMC, 601-354-0304 or write P. O. Box 4665, Jackson, MS 39296-4665.

MFMC also annually presents an Outstanding Physician Award in memory of the late Arthur A. Derrick, M.D.

#### INFLUENZA PROJECT

MFMC is collaborating with three Mississippi hospitals on a project to address the "captive audience" of the hospitalized high-risk influenza Medicare patients. Participating hospitals have established processes to identify patients, provide them with appropriate information and offer immunization against influenza during the "flu season".

The Advisory Committee on Immunization Practices (ACIP) recommends that all persons 65 years of age and older be encouraged to receive the vaccine against influenza. It is estimated that only 30 percent of the high-risks are vaccinated annually. Through encouragement of vaccination for patients admitted September through March, it is hypothesized that the number of high-risk patients immunized against influenza can be improved.

MFMC has also distributed information about influenza vaccination at recent beneficiary programs.

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## **Medical Organization**

## MSMA Member Survey Identifies Concerns

A recent opinion survey of MSMA members indicates that the top 5 issues of concern are:

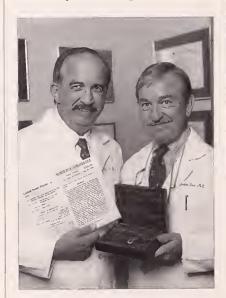
- 1. Government regulation affecting medicine;
- 2. Assuring quality health care;
- 3. Third party involvement in medical decision making;
- 4. Professional liability/malpractice environment; and
- 5. Public image of the medical profession.

In the same survey members were asked to rank current and potential MSMA activities as to their importance and the following top 5 rankings were identified.

- Identify and support an MSMA role in state health planning;
- 2. Continue and strengthen practice management workshops, third party payor representation, and other activities to assist members in dealing with 3rd party payors and government regulation;
- 3. Support and participate in strengthening health policy education as part of the medical school curriculum;
- Sponsor a statewide, physician directed managed care program that can compete with other managed care entities; and

5. Identify and strengthen efforts to place primary care physicians in under-served areas.

### Pascagoula Physician Awarded Patent for Laser Cystoscope



Drs. Paul M. Allen of Pascagoula, and Gordon D. Davis of Phoenix, AZ, inventors of the Modified Kelly Air Cystoscope.

Dr. Paul M. Allen, a gynecologist and obstetrician practicing in Pascagoula, MS was issued Patent #5,342,353 on August 30, 1994 from the U.S. Patent and Trademark Office for his invention of a system for laser treatment of the female urethra and bladder.

The system of this invention discloses a method of urethral colposcopy and colposcopically directed treated laser treatment of the female bladder base and urethra. Dr. Gordon D. Davis of Phoenix, AZ is co-inventor of this instrument. Drs. Allen and Davis have presented this instrument to the American Uro-Gynecologic Society, The American Society for Colposcopy and Cervical Pathology, The American Society for Laser Medicine and Surgery, and the Southern Medical Association. Both physicians authored an article entitled. A New Instrument for the Visualization and Laser Treatment of the Female Urethra and Trigone which appeared in the International Uro-Gynecology Journal in 1992.

Dr. Allen is serving as Director of Continuing Medical Education at Singing River Hospital. Dr. Davis has received appointments as visiting consulting surgeon to Singing River Hospital in 1989 and 1990.

## MSMA Board Conducts Summer Meeting

MSMA's Board of Trustees recently conducted its summer meeting August 27-28, and considered an extensive agenda to include the following reports/actions:

- Authorized discussions with the MS Hospital Association on formation of a joint organization to identify and act on issues of common concern.
- Reviewed semi-annual financial reports of MSMA and its affiliated organizations
- Conducted a strategic planning session and reviewed a recent MSMA membership survey in this regard.
- Filled annual vacancies occurring on committees appointed by the Board.
- Received reports on the status of operations of the MS Physicians Care Network, MS Physicians Insurance Company, MSMA Benefit Plan and Trust and other MSMA affiliated activities.
- Reviewed actions by the House of Delegates at the 1994 Annual Session and directed follow-up activities on those actions.
- Considered the association's position on health legislation to be considered by the 1995 Mississippi Legislature to include a proposed Health Financing Authority, a patient protection law and regulation of physician assistants.
- Reviewed the association's membership recruitment activities and noted an increase in 1994 paid members.
- Directed new activities to strengthen the association's school health education program.
- Approved scheduling of the 1995 Health Issues Forum/Legislative Reception on January 17 with the forum devoted to a program on employer health care management initiatives.
- Approved Funding for the MSMA Alliances "Health Choice '95" program for school children. □

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## The University of Mississippi Medical Center

# UMC Scientists To Study Effects Of Space Flight

Six scientists at the University of Mississippi Medical Center will participate in a history-making space shuttle flight in November.

The project, which seeks to determine the effects of space flight on fetal development, is the first collaboration between the National Aeronautics and Space Administration (NASA) and the National Institutes of Health (NIH) and the first NASA mission to carry pregnant animals into space.

Dr. Roger Johnson, professor of periodontics and anatomy and director of research in the School of Dentistry at UMC, heads up the Medical Center team and is the principal investigator for the \$86,443 grant from NASA.

The pregnant rats will be studied by 10 other research teams (including one from Russia and another from France), all of whom will be looking at how the environment in space, described as microgravity, affects different aspects of fetal development.

The Medical Center team wants to know if microgravity affects the attachment of tendon to bone.

"The tendon is the tough connective link between muscle and bone," Dr. Johnson said. "We know microgravity affects bone and muscle structure, but we don't know if it affects the tendon-tobone juncture. Our hypothesis is that the attachment becomes weakened during exposure to microgravity and may not readily recover normal strength."

And if the hypothesis is true, our pioneers in space may be predisposed to broken bones, tendon tears and muscle injury—by much the same mechanisms as bedridden or older people are predisposed to broken bones because of osteoporosis.

"A loss of bone mass weakens the tendon-tobone juncture," Dr. Johnson says. "We know already that bone loss occurs when the body has little or no contact with the ground. You see this in people who are bedridden, for example. That's why physicians recommend that women walk regularly to prevent osteoporosis."

Osteoporosis is the loss of bone mass, explains Dr. Audrey Tsao, assistant professor of orthopedics in the School of Medicine and member of the UMC research team. "We believe the weightless environment of space will simulate in rats to what happens to humans who have bone loss," she said.

Other members of the UMC team are Dr. Hamed Benghuzzi, assistant professor of health sciences in the School of Health Related Professions, Kenneth St. John, assistant professor of orthopedics (research) in the School of Medicine, Michelle Tucci, senior research associate in the Department of Orthopedic Surgery in the School of Medicine, and Dr. Lyle Zardiackas, professor of restorative dentistry in the School of Dentistry.

The team will study the compositional changes of the rat bones using x-ray analysis and scanning electron microscopy. "The lack of gravity can affect bone mineral composition," said Dr. Zardiackas. "If that changes, the structure changes."

Launch date for the historic ten-day flight of the Space Shuttle Atlantis is November 3 from Kennedy Space Center. The UMC team will split up on the projected landing date so that half the team will go to Florida where the landing is anticipated and half will go to Edwards Air Force Base in California which is the alternative landing site.

"There are no guaranteed landing sites, so we have to be ready," Dr. Johnson says. At the landing, scientists from each team will retrieve the animals to take them back to the lab for testing.

The tissues from the animals which traveled through space will be compared to two control groups. One group stayed aground and went about normal rat business. The other group was subjected to environmental stresses similar to that which the rats in space encountered.

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"When we simulate space flight for rats, we give them food bars instead of pellets and use fans to blow debris out of their cages. If any of the tissue changes are due to stress, we should be able to tell if they also show up in the simulated flight animals," Dr. Johnson says.

At right, Scientists at UMC who will study the effects of space travel on tendon strength are, from left, Dr. Roger Johnson, Dr. Audrey Tsao, Dr. Lyle Zardiackas, Dr. Hamed Benghuzzi, Michelle Tucci, and Kenneth St. John.



# UMC'S Cancer Program Approved By ACS

The Commission on Cancer of the American College of Surgeons (ACS) has granted three-year approval to the cancer program at the University of Mississippi Medical Center (UMC).

Established by the ACS in 1932, the Approvals Program encourages participants to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer. Recognizing that cancer is a complex group of diseases, the program promotes consultation among surgeons, medical oncologists, radiation oncologists, diagnostic radiologists, pathologists, and other cancer specialists. This multidisciplinary cooperation results in improved patient care.

The American Cancer Society estimates that 1,217,400 cases of cancer will be diagnosed in the United States and Puerto Rico during 1994. Slightly more than one-fifth of the country's hospitals have approved cancer programs, and more than 80 percent of patients who are newly diagnosed with cancer are treated in these hospitals.

The commission is composed of fellows of the college as well as other members representing three-cancer-related organizations. It sets standards for approval of hospital and freestanding programs for conformity to these standards.  $\square$ 



UMC PRIMARY CARE DAY — Panelists for the observance of National Primary Care day at the University of Mississippi Medical Center in Jackson were: (from left) Dr. John B. O'Connell, UMC chairman of medicine; Joel Herring, president of the UMC Associated Student Body and a fourth-year medical student; Dr. D. Melessa Phillips, chairman of family medicine and Dr. Owen B. Evans, chairman of pediatrics. The panelists spoke on the "Opportunities and Challenges of Primary Care."

National Primary Care Day is a special program of the Association of American Colleges' Office of Generalist's Physician Programs.

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UMC JOINS COMMUNITY COLLEGE NETWORK
— (from left) Dr. Maurice J. Mahan, dean of the School
of Health Related Professions at the University of Mississippi Medical Center, and Larry L. Johnson, assistant
vice president at South Central Bell, helped coordinate
the debut of the Community College Network (CCN) at
UMC in Jackson. The network will turn on interactive
video classrooms across the state and tie into Mississippi's
largest educational computer network. CCN links
Mississippi's 15 public community colleges, the Mississippi Cooperative Extension Service and UMC. □

#### Dr. Currier Honored

Dr. Robert D. Currier, McCarty Professor emeritus of neurology and first chairman of the department at the University of Mississippi Medical Center, was honored at a dinner hosted by The University Neurology Group, the Department of Neurology, and Dr. and Mrs. James J. Corbett, on Saturday, Oct. 22 at the River Hills

A tour of the department and dedication of the Robert D. Currier Neurology Library took place on Saturday morning on the fourth floor of the Hardy Building and a luncheon followed in the Pavilion. Scientific presentations also were made.

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## **Personals**

Thomas J. Anderson announces his association with MEA Medical Clinics and J. Phil Balaski in the Laurel Clinic, 1515 Jefferson Street, Laurel.

David Bell of Tupelo has associated with the Fulton Family Medical Center. He will divide his time between the Fulton Family Medical Center and the Okolona Family Medical Clinic.

C. Ron Cannon and Jim House co-authored a chapter on "Temporal Bone Trauma" in the text book Otolaryngology.

Ed Hill and John Estes of the Hollandale Clinic are now associated with The Primary Care Clinic, 930 Main Street, Greenville.

James M. Holston and Bert E. Bradford announce the relocation of their clinic to South Central Regional Medical Center, Laurel.

Thomas M. Lehman announces his practice of Internal Medicine, Hypertension and Cardiology, 305 West Moody, Poplarville.

**Richard Long** of Picayune has recently completed requirements by the American College of Surgeons to be certified in Advanced Trauma Life Support.

**Hubert E. Spears**, Jr., of Oxford, announces the opening of his office for the practice of General and Oncologic Surgery at the outpatient Clinic at South Panola Hospital.

F. H. Savoie of Jackson gave a presentation on Arthroscopy of the Elbow at the American Academy of Orthopaedic Surgeons Instructional Course Lecture in New Orleans. He also was visiting professor at the Annual Orthopaedic

Meeting, Shreveport, LA; gave a presentation on Arthroscopic Management of Instability of the Shoulder in San Diego, CA; presentated a paper on Cost Effectiveness in Rotator Cuff Surgery in Workmen's Compensation Patients at the Southern Orthopaedic Association in Bermuda in August and presented a paper on Arthroscopic Management of Carpal Instability at the American Society for Surgery of the Hand in Birmingham.



The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to. Personals Column Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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## **Placement Service**

Journal MSMA Placement and Classified ads are \$2.00/line, with a 4-line minimum charge of \$8.00. There are approximately 50-characters per line in 11 point TR type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

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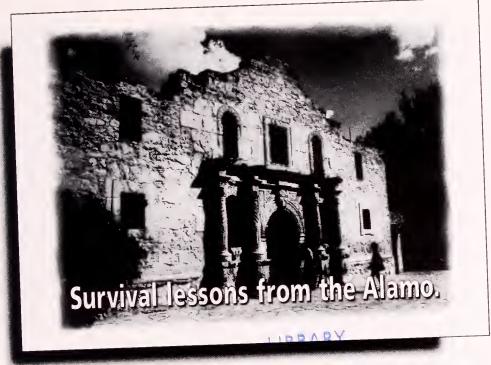
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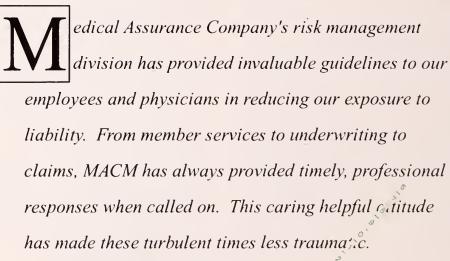
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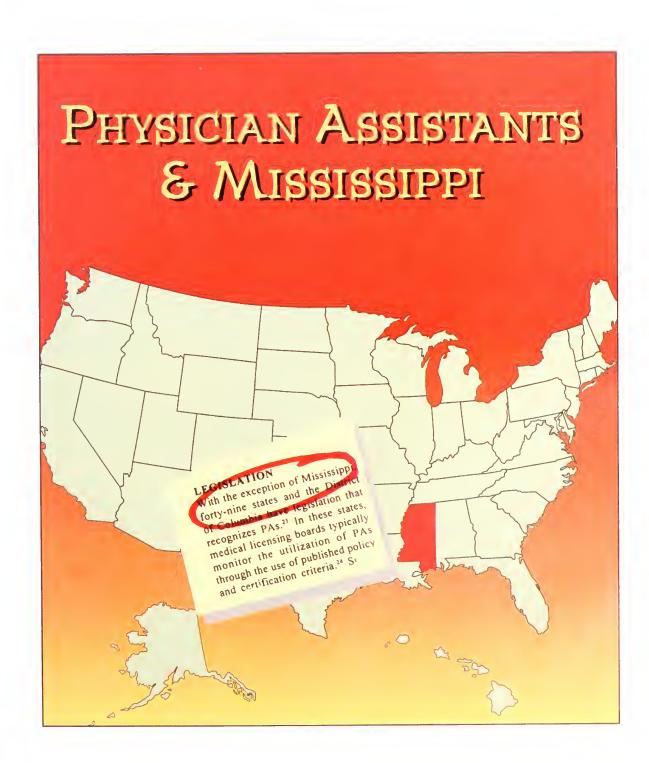
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# Laparoscopic Appendectomy: Have We Found a Better Way?

BRUCE PRUETT, MD JUDIE PRUETT, RN, BSN

Laparoscopic appendectomy is an attractive option for the surgical treatment of acute appendicitis. When performed by an experienced laparoscopist, the procedure can be accomplished with little variation in time from the standard open technique, provide a superior cosmetic result, shorter hospital stay and a significant reduction in postoperative pain and length of convalescence. In this study a comparison of 42 open appendectomies and 37 laparoscopic appendectomies was made in regard to age, sex, length of stay, cost of stay, and length of convalescence.

#### HISTORICAL PERSPECTIVE

Laparoscopic appendectomy was first performed in 1976 by DeKok of the Netherlands,1 but this new technique was not widely reported until Semm began publishing his findings in 1983.2 American surgeons, who had not even thought of removing the gallbladder by an endoscopic approach as yet, had little interest in Semm's new approach. It wasn't until the explosion of interest in laparoscopy brought on by the overwhelming success of laparoscopic cholecystectomy, that American surgeons began to rethink the traditional methods of the most widely used abdominal procedures and adapt them to a laparoscopic technique.

Laparoscopic Appendectomy was not quick to catch on. General surgeons had little incentive to tinker with a well established surgical procedure that was quick,

simple and enjoyed a low complication rate. However, since 1991, a growing number of laparoscopists have turned to laparoscopic appendectomy as better choice for patients with acute appendicitis. Studies are now surfacing 1-6 which show that the laparoscopic approach, while arguably costing more and requiring more operating time, still may provide a safer option with better results than the widely used open procedure.

#### **METHODS**

In this study 42 open and 37 laparoscopic appendectomies were compared on the basis of age, sex, length of stay, cost of stay, incidence of infection, and length of convalescence (see Table 1). All laparoscopic cases were performed in 1992-93. The charges for the 34 open cases performed in 1990-91 were adjusted to 1992 rates to more accurately compare cost. Mean data were analyzed using the two tailed t-test.

#### RESULTS Open Series

In the open series, 42 patients were treated for appendicitis using, primarily, a Rocky-Davis incision. There were 24 males and 18 females ranging in age from 9 to 60 and 3 to 59 respectively. Nine of these patients experienced rupture of the appendix prior to

Acute Gangrenous

surgery. Two experienced postoperative ileus, two had diffuse peritonitis, one had acute periappendicitis with concurrent acute salpingitis which required resection of the fallopian tube, and one had repair of an umbilical hernia concurrent with the appendectomy.

There were 7 cases of infection with open appendectomy. One involved a 3 year old who was readmitted three days after discharge for a WBC of 21,200 with no left shift and no increase in temperature. She had no cellulitis or wound drainage. She was treated for three days with 1V fluids and oral antibiotics. Her WBC returned to normal and she was discharged with no further incidence.

Infection occurred in three patients with ruptured appendicitis who had spontaneous drainage while hospitalized. All responded to IV antibiotics and were treated with oral antibiotics after discharge until drainage ceased. One patient suffered ruptured, gangrenous appendicitis. After discharge he developed a draining wound, which cultured E. Coli and Cl. Clostridiiforme, and a small bowel fistula. He was re-admitted and a excision of the abdominal wall sinus and resection of the small bowel fistula was performed. The patient subsequently healed without further complications. Two patients developed fever and induration of their incisions after discharge. They were treated with

I & D under local anesthesia in the office, and with oral antibiotics. They healed without further incidence. The infection rate in the open group was 16.6%

The length of stay in the open series ranged from one to eleven days with a mean of 3.98. Hospital charges for the procedures performed in 1990 and 1991 were cost adjusted to a 1992 level to more accurately compare them with the laparoscopic series, all of which were performed in 1992 and 1993. The hospital charges for the open appendectomies ranged from \$3,311 to \$13,698 with a mean of \$6,025. Patients were reviewed for the number of days between discharge from the hospital to release to full activity. The range was 8 to 74 days with a mean of 30.4 days.

#### Laparoscopic Series

2

During 1992-93 thirty-seven patients with appendicitis were treated by laparoscopic appendectomy. A 12mm trocar and cannula were placed through the umbilicus and the abdominal cavity insufflated to 15mm intra abdominal pressure. A 5mm cannula was placed just above the right anterior iliac crest. The appendix was located, and the junction of the appendix and cecum identified. A window was then dissected in the mesoappendix and an endo-GIA 30 stapler was placed across the base of the appendix and fired,

Table 1 — CASE DIAGNOSIS DISTRIBUTION			
DIAGNOSIS	OPEN	LAPAROSCOPIC	
Acute Appendicitis	33	31	
Acute Suppurative, ruptured	9	4	

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Table 2 — PATIENT CHARACTERISTICS AND STATISTICAL OUTCOMES

	Laparoscopic Appendectomy	Open Appendectomy	
Number of Cases	37	42	
Age *	26.89 ± 2.8	23.98 ± 2.2	p = .4141
M : F	16:21	24:18	p = .2227
Hospital charges *	7302 ± 251	6025 ± 419	p = .0135
Length of stay *	2.51 ± .2	3.98 ± .3	p = .0001 +
Return to full activity*	9.7 ± .72	30.4 ± 2.0	p = .0001 +
Infection rate Number: %	2:5.4%	7:16.6%	

<sup>\*</sup> Mean ± SE

transecting the appendix from the base of the cecum. The appendix was removed via an endo bag. Following removal of the appendix the abdominal cavity was inspected for other pathology, the right lower quadrant was irrigated, the cavity suctioned and the C02 vented. The puncture sites were closed with O-Vicryl on the fascia and 4-O Vicryl subcuticular stitches on the skin, then covered with an transparent dressing.

In the laparoscopic series there were 16 males and 21 females ranging in age from 9 to 62 and 7 to 85 respectively. The length of stay in this series was from one to five days with a mean of 2.51 days. Patients were released to full activity from 3 to 29 days with a mean of 9.7 days.

Of the 37 patients treated with laparoscopic appendectomy four had experienced rupture of the appendix prior to surgery and three had peritonitis. There were only two occurrences of postoperative infection in this group, both docu-

mented on post discharge follow up. One patient experienced mild erythema and induration of the umbilical puncture site which resolved with heat and oral antibiotics. He experienced no drainage. The second patient developed diffuse cellulitis of the lower abdominal wall that required I & D and oral antibiotics. He healed without further complication. The infection rate in the laparoscopic series was 5.4% (see Table 2).

Hospital charges ranged from \$4,180 to \$10,840 with an average cost of \$7,302. All charges in this series were incurred during 1992-93 and no cost adjustments were made.

#### DISCUSSION

The majority of general surgeons have been of the opinion that removing the appendix by the open method is faster, cheaper and safer. When actually comparing the two approaches however, some thought provoking statistics come

to light.

Appendectomy can be achieved more quickly with the open approach. This study did not include operating time since the patients of only one surgeon were used, but the literature reports a time variance between the two methods, with the laparoscopic approach being longer. Schroder reports an average open time of 45.4 minutes and laparoscopic time of 60.1 minutes3, and Richard's series reports 61.2 and 76.2 minutes respectively.4 On the surface, the open method appears to be the clear winner. However, average operative time depends on several factors. It is accepted that there is the possibility of a wide variance in operating time between individual surgeons due to personal preferences or use of differing styles, ie: the surgeon that ties off bleeders will have a longer case time than the one who coagulates them. In laparoscopy, the more one uses the technique the less time it requires. In this study, while operating time was

<sup>+</sup> Highly significant

not formally reviewed, it was noticed that after the first 20 laparoscopic appendectomies were performed, actual operating time fell within approximately 15 minutes of the average of the open operating time. This indicates that after the learning curve has passed, time difference between the two procedures should be approximately the same. This is consistent with the findings in the studies performed by Schroder and Richards. Another consideration is the diagnostic feature laparoscopy allows. The surgeon is able to thoroughly inspect the abdominal contents at the time of appendectomy. Adhesions can be lysed, and suspicious lesions or lymph nodes can be biopsied. The few extra minutes required to inspect the abdomen are well spent and an advantage not possible during open appendectomy. In the case of a normal appendix, the surgeon who has explored via the open route still doesn't have the answer to his differential diagnosis. If he explores laparoscope, he can rule out the appendix as the source of concern look further for the causative factor.

Charges for laparoscopic appendectomy tend to be higher than those incurred for its open counterpart. In the studies reported by Richards<sup>4</sup> and Cohen<sup>5</sup> the cost difference did not reach statistical significance. In this study the cost difference was moderately significant. In today's cost conscious society, an effort to reduce or eliminate the cost difference would include reducing the operative time and the routine use of reusable laparoscopic equipment at surgery. The institution where this study was conducted uses only disposable staplers and cannulas.

The length of stay, which is already reduced in laparoscopic cases, will likely continue to decrease, and most patients could probably be safely discharged within 24 hours and followed on an outpatient basis. The primary factor controlling the length of stay appears to be postoperative pain. In the studies conducted by Schroder<sup>3</sup> and Richards<sup>4</sup>, postoperative pain medication was tracked and found to be significantly reduced in the laparoscopic patients. These patients also experience fewer gastric problems, tolerate diet within the first 24 hours and are able to increase activity much more quickly than patients who have had the traditional open procedure.

One factor to consider when looking at the cost of laparoscopic appendectomy is the economic value of the productivity gained by releasing patients to full activity significantly sooner. In this study the mean time for release to full activity in the laparoscopic series was 9.7 days versus 30.4 days in the open series. This is highly significant (p=.0001), and the economic impact on those who are employed and on their employers is impressive. It would be impossible to quantitate the savings realized by the significant reduction of time required for a full release, but common sense would dictate that it more than compensates for the increased hospital charges in the laparoscopic series. By combining the length of stay and return to activity for both groups, the total average time a patient would require to recover from acute appendicitis can be compared by surgical approach. The mean for the open series is 34.36 days, versus 12.22 days for laparoscopic patients. This is highly significant (p=.0001) and demonstrates that on average, a patient who is treated with open appendectomy will require 65% more time to return to full activity than the

patient treated with an laparoscopic procedure.

Laparoscopic appendectomy enjoys a much lower rate of infection. In this study there were only two wound infections (5.4%) in the laparoscopic series, versus seven (16.6%) in the open group. Similarly, Nowzaradan has reported respective infection rates of 1% and 16% in his series of 200 patients.6 The dramatic reduction of infection in laparoscopic appendectomy can be partially explained by the ability to locate collections of purulent fluids, evacuate them and thoroughly suction remaining bacteria out of the abdomen. The ability to remove the contaminated appendix without risking contact with the soft tissue of the abdominal wall is a vital factor in reducing the incidence of subcutaneous infection postoperatively.

Laparoscopic puncture sites are approximately one centimeter in length, versus the five centimeters or more required for the open procedure. Although the incidence of the development of a hernia from a open appendectomy incision is small, it has never been reported in laparoscopic puncture sites. As one would expect, the two small puncture sites, one hidden in the navel, are virtually invisible on the abdominal surface/guaranteeing a superior cosmetic result. While this is not a major concern for the surgeon, it does add considerably to patient satisfaction.

#### **SUMMARY**

It is certain that general surgery is moving towards less invasive procedures. Laparoscopic appendectomy, while just now gaining in popularity, appears to be a better choice for most patients than its time honored counterpart. The only disadvantages identified since

the inception of the laparoscopic approach are a longer operating time, which is justified because of the increased diagnostic opportunity, and the difference in cost, which is quickly narrowing and becoming insignificant. With its many advantages, combined with the fact that it is one of the least difficult laparoscopic procedures to perform, it will surely quickly become the standard procedure to evaluate right lower quadrant pain and associated symptoms of appendicitis.

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- Dr. Pruett is a board certified General Surgeon affiliated with South Central Regional Medical Center in Laurel, MS.

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#### Physician Assistants and Mississippi

GEORGE L. WHITE, JR., PhD, MSPH, PA-C CHARLES P. EGERTON, PhD, MPH, MS, PA RONALD MYERS, MD ROBERT D. HOLBERT, MD

Mississippi remains the only state that does not have legislation recognizing physician assistants (PAs). Currently, there are approximately 27,000 PAs nationwide and 27 PAs within the state. Most Mississippi PAs are employed by the United States military and Veterans Administration. Others are associated with colleges and industries or live in Mississippi and commute to adjoining states where their supervising physicians' practices are located.

The sparsity of PA practice settings in Mississippi has limited the profession's visibility, thus hindering initiatives for obtaining PA enabling legislation within the state. A PA program was established at the University of Mississippi Medical Center in 1972. This program graduated a few students before being dissolved for fiscal reasons in 1974. In the early 1980s several attempts were made to introduce PA legislation in Missis-

sippi, but general unfamiliarity with the profession and a lack of strong grass roots support combined to undermine these efforts.

Health care reform proposals reported in the recent medical and popular news are replete with references to "mid-level providers," usually implying physician assistants, nurse practitioners, and certified nurse midwives. Recent proposals advocate increased utilization of these health care providers

Clearly, the utilization and distribution of PAs within the nation's health system is expanding. The Surgeon General's attitude toward PAs is expressed in the U.S. Public Health Service's 1991 report to Congress: "PAs have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing costeffectiveness of care." The report additionally states that widespread utilization of PAs can materially

increase a physician's practice productivity and that PAs "...are capable of carrying substantial proportions of the workloads of primary care physicians."<sup>2</sup>

The purpose of this article is to provide an overview of the PA profession in terms of history, capabilities, services, utilization, supervision, legislation, and prescriptive practices.

#### HISTORY

The combination of a number of factors during the 1960s resulted in an unprecedented need for practitioners in primary care medicine. This was a time of robust economic growth. The advent of Medicare and Medicaid opened clinic doors to many people who had rarely, if ever, visited physicians. Increased emphasis was placed upon preventive medicine and the need for regular health checkups. The percentage of physicians in general practice declined

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precipitously while the number of specialists increased. Seventy-six percent of the American physicians in 1925 practiced general medicine; however, by 1967 the specialist trend had reduced general practitioners in the total physician population to 39%.3 The effects of the baby boom were beginning to be felt, and parents were insisting upon medical care for pediatric matters that had heretofore been largely ignored. Toward the end of the 1960s, these and other factors combined to create unusual stresses upon the primary care delivery system within the United States.

Americans were anxious for solutions to the decreasing accessibility and rising costs of health care. A novel approach, designed to mitigate these concerns, was proposed by Dr. Charles Hudson in an article published by the Journal of the American Medical Association regarding a new type of clinician. This health care provider would play an intermediate role between a technician and physician who "...could not only handle technical procedures but also take some degree of medical responsibility."4 Such a clinician would complete two years of a liberal arts curriculum followed by two years of medical education and "externship."

This concept was advanced and brought to fruition by Dr. Eugene Stead, Jr. at Duke University Medical Center. In 1965, Dr. Stead initiated a "physician's assistant" program involving former military corpsmen. His motive was to educate a cadre of practitioners who could "...assist doctors in their clinical and research endeavors in such a way as to facilitate the better utilization of available physicians..."5 Dr. Stead and others had made overtures to the National League of Nursing for expanding the roles of nurses to include such duties. However, these approaches were rebuffed by nursing executives who, at the time, could not support the concept.<sup>6</sup>

The Duke PA program received widespread support within the medical community, and patients were very receptive to this new type of provider.7,8 Community based preceptors participating in Dr. Stead's program were the first to understand the benefits of having skilled assistants to help share the burdensome responsibilities of private practice. Many overworked rural and urban primary care physicians found that they could spend more time with very ill patients and engage in such luxuries as traveling to medical conferences for updating their knowledge and skills.6

The latter part of the 1960s saw the establishment of similar PA programs at the University of Oklahoma, Johns Hopkins University, Yale University, the University of Alabama, George Washington University, Emory University, and Wake Forrest University.<sup>8</sup>

During the early 1970s, the PA profession achieved recognition by the American Medical Association.9 Many new programs were put in the planning stages as demand for this innovative type of practitioner grew. Physician assistant legislation had been passed in about half the states, and a national PA registry, accreditation, and certifying agencies were under development.3 It is significant that licensure to perform specific tasks independent of supervising physicians was never a part of the PA philosophy. From the beginning, PAs functioned in a dependent relationship with physicians. The physician determined the degree of the assistants's autonomy in performing certain therapeutic tasks based upon demonstrated competency.10 Particular limitations were determined by specific legislation enacted at state level.<sup>11</sup>

Prospective students were attracted to the rapidly developing PA profession. This led to increasing standards in selecting program applicants. Military corpsmen were no longer the prime candidates for recruitment. During the mid-1970s, university administrators of PA programs started to stipulate curriculum prerequisites compatible with the award of a bachelor's degree upon graduation. Specialty PA programs in surgery, urology, orthopedics, neonatology, family medicine, geriatrics, pediatrics, gynecology, occupational health, and community medicine appeared.12

Currently, there are 59 accredited PA programs in the United States, and approximately twelve more programs are expected to receive national accreditation by 1997. Twelve are at the master's level. 15

#### CAPABILITIES AND SER-VICES

The academic standards upon which PA academic criteria and curricula are based derive from: The Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician.13 This document was collaboratively prepared and adopted by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine. The Essentials establishes the standards of quality for program accreditation and is under the administrative control of the Commission on Accreditation for Allied Health Education Programs. It has undergone several revisions, the latest of which occurred in 1990.

The capabilities and functions of PAs are explained in The Essentials: "Physician assistants are academically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and application focused of the physician's particular knowledge."

The clinical services for which PAs may be employed are paraphrased from *The Essentials*.

- 1. Evaluation: Initially approaching a patient of any age in any setting to elicit a detailed and accurate history, performing an appropriate physical examination, delineating problems, and recording and presenting the data.
- 2. Monitoring: Assisting the physician in conducting rounds in acute and long-term patient settings, developing and implementing patient management plans, recording progress notes, and assisting in the provision of continuity of care in office based and other ambulatory settings.
- 3. **Diagnostics**: Performing and/or interpreting common laboratory, radiological, cardiographic and other routine diagnostic procedures used to identify pathophysiological processes.
- 4. Therapeutics: Performing routine procedures such as injections, immunizations, suturing, wound care, management of simple conditions produced by infection or trauma, and assistance in the management of more complex illness and injury—which may include assisting surgeons in the conduct of operations, performing evaluation and therapeutic procedures in response to lifethreatening situations, and pre-

scribing designated medications.

- 5. Counseling: Instruction and counseling of patients regarding compliance with prescribed therapeutic regimens, normal growth and development, family planning, emotional problems of daily living, and health maintenance.
- 6. **Referral**: Facilitating the referral of patients to community health and social service agencies when appropriate.

#### UTILIZATION

The initial utilization envisioned for PAs was to help augment the geographic maldistribution of physicians practicing in rural areas.14 However, as the profession has evolved, PAs have tended to fill other medical niches for which there is high practitioner demand. According to a 1993 demographic survey conducted by the American Academy of Physician Assistants, 34% of the 23,350 PAs in clinical practice are found in towns with populations less than 50,000. Fifty-four percent of the PAs are located east of the Mississippi River-25% employed in the Southeast alone.15

Thirty-five percent of the PAs are involved in family or general practice, 10% in internal medicine, 2% in pediatrics, 6% in general surgery, 21% in surgical specialties, 6% in medical specialties, 8% in emergency medicine, and 3% in occupational medicine. The remaining PAs (9%) are employed in pediatric specialties, physical and rehabilitation medicine, psychiatry, public health, radiology, academia, and industry.<sup>15</sup>

The average PA is 40 years of age, works 42 hours per week, has 30 hours of weekly on-call responsibilities, and earns an average of \$53,000 yearly. Fifty-eight percent are men, although women have predominated as PA graduates

since 1980. The starting salary for PAs is between \$40,000 and \$45,000, with seven jobs available for every graduate. Eighty-five percent of the PAs have bachelor's degrees, 12% have masters' degrees, and 1% have earned doctorate degrees. Seventy-five percent of the PAs are found in outpatient settings where they each see an average of 22 patients per day. The remaining 25% of the PAs are employed in private, public, and federal hospitals.<sup>16</sup>

#### **SUPERVISION**

Physician assistants do not practice independently; this is explicit in the philosophy of the profession and is enforced by regulatory state laws.3 The unchanging tenet of PA profession is the dependent relationship that binds the PA with the supervising physician.17 This relationship begins in PA school where physicians provide most of the instruction in a curriculum following the medical school model.15 It is typical for PA students to share classes, facilities, and clinical rotations with medical students. Consequently, physicians and PAs develop a similarity in medical reasoning during their schooling that eventually leads to a homogeneity of thought in the clinical workplace.17 This type of alliance is particularly valuable in the adaptation of PAs to the individual practice patterns of their supervising physicians. By contrast, very few nurse practitioner programs utilize core faculty members from disciplines other than nursing, and most offer significantly less clinical training than PA programs.18

A widespread trend in the utilization of PAs is to staff family practice clinics in Health Maintenance Organizations (HMOs) and military clinics with physician and PA teams. Kaiser Permanente

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Northwest Region constructs its teams with a ratio of one PA to two physicians.19 The Air Force typically has two PAs for each physician preceptor.20 This mix of physicians and PAs has been demonstrated to enhance access to primary care services while improving efficiency and cost effectiveness. Studies have shown that such team strategies have generated important benefits without any diminution in the quality of health services performed.21 One such study indicated that the introduction of a PA into a single physician's practice would increase productivity by 49% to 74%.20

Appropriate consultation is a key element in a successful physician/PA relationship. Although PAs have proven capable of managing about 75% to 80% of the patients in a typical primary care setting, such management is often facilitated by brief consultations on a case-by-case basis. 15,20 When a PA is making a house call or performing medical duties in a geographically isolated area, any necessary consultation usually occurs via telephone or radiophone. 22

#### **LEGISLATION**

With the exception of Mississippi, forty-nine states and the District of Columbia have legislation that recognizes PAs.23 In these states, medical licensing boards typically monitor the utilization of PAs through the use of published policy and certification criteria.24 Supervising physicians determine the standards of PA services within these legal guidelines and "...are vicariously liable for services performed by their PAs under the legal doctrine of respondeat superior."15 Thus, PAs are the agents of their supervising physicians but are governed by the regulatory limits established by state legislation and licensing boards. In this regard,

PAs are directly liable for their services to patients and, in some cases, maintain their own malpractice insurance policies.<sup>24</sup>

#### PRESCRIPTIVE PRIVILEGES

Seventy-five percent of the states (38 states and the District of Columbia) have prescriptive legislation for PAs.<sup>15</sup> The prescription of scheduled substances varies from state-to state, but the prescribing of medications—scheduled as well as nonscheduled—is done only with the agreement and oversight of the supervising physician.<sup>25</sup>

Prescriptive privileges for PAs have been found to be particularly advantageous in rural states that tend to be medically underserved. In Texas, for example, lawmakers passed PA prescriptive legislation in 1991. One year after passage of the legislation, the number of rural health clinics quadrupled and the percentage of PAs practicing in rural areas tripled. A similar influx of PAs to rural areas occurred in Montana upon passage of prescribing legislation. English of Passage of prescribing legislation.

#### CONCLUSION

The demography of Mississippi is such that many citizens have poor access to basic medical care and preventive health services. Over 60 of Mississippi's 82 counties are designated as health professional shortage areas for primary care.<sup>27</sup> Practicing under the supervision of physicians (the only way PAs are allowed to practice), PAs have proven their competence for improving access to quality health care. Payment is made to the physician/PA practice, not to the PA alone.17 The proven success of physician/PA teams in extending health services to underserved areas appears to be a perfect match for the Mississippi medical care paradigm.

It is explicit in the Mississippi

State Health Plan that "Availability of competent health personnel in sufficient numbers to meet the population's needs is essential to high quality health care services. Mississippi is traditionally a medically underserved state, with certain areas that are grossly underserved."27 Physician assistants, working with physicians, promote better distribution of health care services and can improve accessibility to care in rural areas and underserved communities. Enabling legislation will allow these highly skilled physician dependent practitioners to help Mississippi's current and future health care needs.□

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#### Important Information for Physicians

#### The Patient Protection Act

Mississippi is poised to follow a nationwide trend as insurance companies and other for-profit businesses form large new managed care organizations. Often these plans cut costs and increase profits by limiting what a physician can do for a patient. The result can be arbitrary denial of coverage for medical care a patient needs.

To protect Mississippi patients, physicians and allied health professionals have joined together to support passage of *The Patient Protection Act* to confront "bottom line" incentives to limit health care coverage and protect patients from unfair insurance practices. This consumer-oriented bill would require disclosure of policies that restrict the type and kind of health care covered by an individual's insurance plan.

The Patient Protection Act was developed by the Mississippi State Medical Association to guarantee that Mississippians continue to receive the medical care deemed appropriate by their doctors — not by the big insurance companies — and to protect physicians from arbitrary exclusion from managed care networks.

MSMA will pursue passage of The Patient Protection Act in the 1995 session of the Mississippi Legislature.

#### Highlights of The Patient Protection Act

- Credentialing criteria must be disclosed to network applicants and a network participant would be entitled to his/her practice profile.
- Credentialing decisions must be public record and any physician whose application is denied or whose participation in a network is terminated shall have the right to appeal that decision and be afforded a due process hearing.
- Local physicians must be available to the consumer in both urban and rural areas. Patients can
  only be forced to travel far from home when a needed treatment is not available from a local
  physician or when no local doctor has joined the managed care network.

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- Patients with expensive medical conditions will be protected from discrimination that occurs when treatment by a doctor whose practice includes a large number of patients with high-cost illnesses is excluded from coverage by the insurance plan.
- Restrictions on the type and kind of health care covered by an individual's insurance plan, as well as co-payments charged to the enrollee and medical services or supplies not covered by the plan, must be communicated to the consumer.
- Data used to determine what medical procedures are not covered must be made available to
  patients and physicians. And doctors are guaranteed input into the utilization review policies
  that determine levels and kinds of medical treatment to be covered for patients enrolled in the
  plan.
- Individuals must be provided easy-to-understand information on coverage provisions, benefits and medical exclusions not covered by a managed care plan. And, confidentiality of the patient's and physician's medical records must be maintained.
- Insurance companies must disclose any financial arrangements that will reduce covered medical care by refusing to pay for specific treatments or restrict the patient's referral to another health care specialist.
- State Department of Health certification of managed health care plans operating in Mississippi will safeguard access to policies that determine what treatments and procedures are covered under an individual's medical insurance.

DRAFT LEGISLATION

AN ACT TO REQUIRE THAT ANY MANAGED CARE ENTITY OPERATING IN MISSIS-SIPPI BE ISSUED A CERTIFICATE OF AUTHORITY; TO REQUIRE THAT CERTIFICATES OF AUTHORITY BE RENEWED ANNUALLY; TO PROVIDE FOR THE PROTECTION OF PATIENTS AND PROVIDERS OF HEALTH CARE PARTICIPATING IN MANAGED CARE PLANS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This act shall be known and may be cited as "The Patient Protection Act".

SECTION 2. As used in sections 1 through 6 of this Act:

- (a) "Department" shall mean the State Department of Health.
- (b) "Managed care plan" shall mean a plan operated by a managed care entity as described in subparagraph (c) that provides for the financing and delivery of health care services to persons enrolled in such plan through:
  - (i) arrangements with selected providers to furnish health care services;

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- (ii) explicit standards for the selection of participating providers;
- (iii) organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution; and
- (iv) financial incentives for persons enrolled in the plan to use the participating providers, products, and procedures provided for by the plan.
- (c) "Managed care entity" shall include a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as described in subparagraph (d) that operates a managed care plan.
- (d) "Managed care contractor" shall mean a person or corporation that
  - (i) establishes, operates or maintains a network of participating providers;
  - (ii) conducts or arranges for utilization review activities: and
  - (iii) contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.
- (e) "Participating provider" shall mean a physician, hospital, pharmacy, dentist, nurse, chiropractor, optometrist, or other provider of health care services licensed or certified by the state, that has entered into an agreement with a managed care entity to provide services, products or supplies to a patient enrolled in a managed care plan.
- SECTION 3. The department shall establish a process for the certification of managed care plans offered or provided to persons residing in Mississippi. No such plan shall be offered or provided to persons residing in this state unless it has been certified by the department. Any managed care plan certified by the department must be recertified annually, and the department shall establish procedures to ensure the continued compliance with the requirements of Section 5 through the recertification process. The department shall terminate the certificate of any managed care plan if such plan no longer meets the applicable requirements for certification. The department shall provide any such plan with an opportunity for a hearing on the proposed termination.
- SECTION 4. The department shall establish a fee to cover the costs of issuing and renewing the certifications authorized by this act.
- SECTION 5. In order to be certified and recertified by the department pursuant to this act, a managed care plan must:
  - (a) Provide prospective enrollees in managed care plans with written information on the terms and conditions of coverage. All such information must be in a readable and understandable format, consistent with standards developed by supplemental insurance coverage under Title XVIII of the Social Security Act as set forth in Section 83-9-101, et. seq., Mississippi Code of 1972. This information must be standardized so that potential enrollees can compare various plans. Specific items that must be included are:
    - (i) coverage provisions, benefits, and any exclusions by category of service or provider;

- (ii) any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and any procedures that may lead the patient to be denied coverage for or not be provided a particular service, product or supply;
- (iii) financial arrangements or contractual provisions with any provider of health care services or supplies that would limit the type of services and products covered, restrict referral or treatment options, or negatively affect the provider's fiduciary responsibility to the patient, including, but not limited to, financial incentives not to provide medical or other services or supplies; and
- (iv) an explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for co-payments and other non-covered or out-of plan services or supplies.
- (b) In order to ensure that patients can receive covered services in a timely fashion with minimum inconvenience, plans must demonstrate that they have adequate access to physicians and other providers located in the proximate area as the enrollee. This requirement cannot be waived and must be met in all areas where the plan has enrollees, including rural areas. Plans may require that an enrollee utilize a provider outside the area where the enrollee resides only where the necessary services are not otherwise available locally or where the service needed by the enrollee is not available from a provider who has agreed to contract with the managed care plan for the provision of such services.
- (c) Plans shall be required to establish a process through which providers whose services are covered by the plan provide input into medical policy, utilization review and procedures, quality and credentialing criteria, and the medical management of patients.
- (d) Plans shall be required to establish a credentialing process for all providers participating in the plan. The credentialing process shall:
  - (i) be based on objective standards which shall be available to both provider applicants and enrollees;
  - (ii) when economic considerations are part of the credentialing process, objective criteria must be used and must be available to applicants, participating providers and enrollees. Any economic profiling of providers must be adjusted to recognize case mix, severity of illness, age of patients and other features of a provider's practice that may account for deviations from expected or projected costs. Profiles must be made available to those so profiled;
  - (iii) plans shall be prohibited from discriminating against enrollees with expensive medical conditions by excluding providers with practices containing a substantial number of such patients;
  - (iv) all credentialing decisions shall be made on the record and the applicant shall be provided with all reasons if the application is denied or the contract not renewed;
  - (v) any provider whose application is denied or contract not renewed shall have a right

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- to appeal the decision and be afforded a due process hearing with the right to present evidence in his or her behalf. The appeals process shall be approved and closely monitored by the department to ensure its fairness; and
- (vi) the same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to termination of a contract, the provider shall be furnished with notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state licensing or certification board or other government agency that effectively limits the provider's ability to practice within the jurisdiction.
- (e) Procedures shall be established to ensure that all applicable federal and state laws designed to protect the confidentiality of provider and individual medical records are followed.
- (f) The screening criteria, weighting elements, and computer algorithms utilized in the managed care plan's utilization review process and their method of development must be made available to providers and enrollees upon request. Such criteria must be based on sound scientific principles and developed in cooperation with the affected health care providers.
- SECTION 6. If the managed care plan to be certified pursuant to this act is a health maintenance organization, such HMO must also satisfy the requirements of Section 41-7-401, Mississippi Code of 1972.
- SECTION 7. The department shall adopt regulations to implement the provisions of this act and may obtain any information from managed care plans that is necessary to determine if such plan should be certified or recertified.
- SECTION 8. This act shall take effect and be in force from and after July 1, 1995.

# MSMA Health Issues Seminar and Legislative Forum

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The President's Page MALLAN G. MORGAN, MD

#### PATIENT PROTECTION

ouldn't it be great if it were all protected. Our families, our practices, and our patients would be of less concern if we knew all of them were protected. Unfortunately, this is not the case. There are drive by shootings, guns in schools, crack heads (it seems) everywhere and an apparent increase in domestic violence. Our families are not as safe as we would wish and what about our patients? Well, they aren't safe either. With the influx of managed care into Mississippi our practices will change and our patients may be adversely affected.

I don't know what we can do about society as a whole. I wish I did. I have discussed these societal problems with Mrs. Karen Stevens, President of the MSMA Alliance. She and her members are planning to address at least part of this problem. But what is MSMA going to do to protect the physician/patient relationship?

The Board of Trustees has spent a lot of time and energy on this question, and has come up with a proposal patterned after the AMA "Patient Protection Act". Do not be confused — if our patients' rights are protected (the right to choose their physicians, the right to see a physician in their own area who has the proper credentials to treat their problem, and the right to know if their care might be limited in any way), then the physician/patient relationship will be also protected. Let's be honest! Managed care means to the insurance companies only one thing. It means less money paid to doctors and hospitals to achieve greater profits for their companies. Their interest is the bottom line, not the welfare of the patient nor the physicians' financial ability to remain in practice. I refer you to the President's Page from August on "Fatal Cure" by Robin Cook.

What the Patient Protection Act does offer as advantages to patients and their physicians are the following:

- Requiring managed care plans to provide prospective enrollees with information on coverage restrictions and exclusions, utilization review requirements, and financial arrangements that would limit the services offered, restrict referrals or provide incentives to not deliver certain services.
- 2) Requiring plans to demonstrate that they provide adequate access to Mississippi physicians that are within reasonable distance of the patient.

(Continued on page 366)

#### **Editorials**

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION VOLUME XXXV, NUMBER 12 DECEMBER 1994

ot often does one have the opportunity to work closely with a person such as W. Moncure Dabney, MD. And when such a relationship comes to an abrupt end, the real and lasting values of that relationship become more apparent. Having worked closely with Dr. Dabney for twenty-five years, I can truly say that he was the extreme gentleman and scholar, the ideal family physician and an outstanding member and proponent of organized medicine. Although he served his local and state medical societies in many capacities, Dr. Dabney had a special place in his heart for The Journal Of The Mississippi State Medical Association. For many years he served as editor, and then as editor emeritus. He continued to be a very active member of the Publications Committee until his recent death. He approached these duties and obligations like he did all others, with a resolve to continually improve the Journal. He was very concerned about publishing a Journal dedicated primarily to helping Mississippi physicians continue to grow professionally, while at the same time keeping them informed on the socioeconomic aspects of medicine in Mississippi. Under his directorship the Journal steadily improved, changing dramatically from its predecessor, The Mississippi Doctor, to the current Journal MSMA. Dr. Dabney will be missed by all his colleagues and friends, but his absence will be particularly noted by the Journal MSMA staff. We pledge to continue the efforts of Dr. W. Moncure Dabney.

> Myron W. Lockey, MD Editor

# REVAMPING THE COMPONENT SOCIETIES

Since the inception of organized medicine as we have known it, the local or component societies have been the heart of the program. I well remember my first local society meeting thirty years ago. The house was packed and there was a lively and lengthy debate censuring the actions of some of the members for prescribing "Fat Pills" for the treatment of obesity. I was very impressed that the society had prepared for the debate and insisted on protecting patients from unwarranted therapies. Almost every physician in the community was there.

For a period of ten years the attendance at local society meetings was very good with active participation by the membership. During this time the primary problems discussed were related to patient care. From 1975 to 1985 there was a gradual but progressive decline in activity with decreased attendance and much less active membership participation. During this period the issues presented shifted away from patient related problems and became more oriented to third party problems facing the membership. The third ten year period, 1985-1995, has seen and will see even further decreases in attendance and participation with a major increase in non-patient oriented problems.

The changes described are not unique to Mississippi. Recently the AMA's Council on Long Range Planning and Development conducted an in depth (Continued on page 366)

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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#### President's Page

(Continued from page 364)

- 3) Requiring plans to make available to physicians their credentialing criteria and individual profiles, and provide a physician with the reasons for not accepting or renewing a contract to participate in a plan.
- 4) Requiring plans to provide a due process mechanism for allowing a physician to appeal a decision to refuse or discontinue his or her participation in a managed care plan.

I ask you to remember that with the single exception of the Mississippi Physicians Care Network (MPCN), at the present time, there is no managed care entity in Mississippi that has as its' primary concern the welfare of the patients and the physicians in our state. They are here to make a buck! If they can make their profit without the patients and physicians suffering, then that's great. But if they can't, then we as patients and physicians will have to suffer for their greed. Therefore, I encourage you to support and ask your legislators to support the "Patient Protection Act". It will protect your patients, but it will also protect us.

Mal

Editorial Note: The "Highlights of the Patient Protection Act" and a draft of the proposed legislation are printed as a Special Article in this issue of the Journal MSMA on page 358.

#### **Editorial**

(Continued from page 365)

review of the current status and relevance of the local societies in today's medical marketplace. This study suggest that local, or county, societies are going to have to respond immediately, changing their structure and programs to meet the needs of today's physicians

Specialization and increased involvement in, and by, the specialty societies, marked changes in third party involvement, redistribution of practices and development of large practice groups, changes in the legal atmosphere, new developments in hospital-physician relationships and marketing, decreased resources associated with the medical dollar, competition for the time and interest of physicians and lack of any cohesive agenda to bind the diverse groups seen in medicine today are all reasons for the current changes.

To survive, local societies will have to address the issue of their position and relevance in today's world. They must concentrate on issues not being addressed by other groups and in particular continue to be spokesmen for the citizens of Mississippi, our patient population. The local societies cannot continue as they have in the past, trying to be the total resource for defining and addressing the problems facing today's physicians.

This matter has been discussed by the Mississippi State Medical Association in recent months and these discussions should be stepped up into high gear, as now is the time to define changes that will recreate the goals and objectives of our component societies, making them more attractive and meaningful to today's physicians.

> Myron W. Lockey, MD Editor



JOURNAL MSMA



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Yes, I would like to serve as "Doctor of the Day" during the 1995 Legislative Session and have indicated my choices of dates below.

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-	-	5		
10	11	12		
17	18	19		
24	25	26		
31				

February				
Tues.	Wed.	Thurs.		
	1	2		
7	8	9		
14	15	16		
21	22	23		
28				

March				
Tues.	Wed.	Thurs.		
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14	15	16		
21	22	23		
28	29	30		

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To the Editors, Journal MSMA

#### Health Care, Doctors, and Patients

For the first years of my working life, I paid for my own and my family's health care. The premiums were deducted from my salary. When I began work for the State of Mississippi, it was the same. Then one year when no insurer would bid on the State workers' contract, the Legislature created the present State Self-Insured plan (administered by Blue Cross), and the employers began to pay the premium for the worker, who then paid only for the family which I believe is still true.

For the most part, I have always been happy with my health plan. There was always a deductible, and there were always limitations, and the insured paid 20% up to a point when 100% was covered. I don't think anyone hoped for more than that. Now that my wife and I are retired, generally, I am still happy with it, and I hope it will act as a supplement to Medicare.

Then, in a well-intentioned, but misguided effort to save money, a number of restrictions were applied. Among them were the Key Physician and Community Pharmacy concepts. These were providers (it is not correct to refer to physicians and hospitals as "vendors") who were willing to accept the fees which the system decided were enough. This was the start of the crack in the dam.

Now a great dark shadow has risen over the eternal prerogative of the patient to choose a physician and to have that care provider Provide (the patient concurring) the care thought best. The cloud is in the nature of what I refer to as "a little girl with a book" who sits in an office somewhere in Madison County, and (before I can have medical

care), must tell my physician (a) whether I can be in a hospital, (b) for how long, (c) if I can have surgery, (d) under what circumstances, (e) what type and how much medication I can have, and (f) what follow up services are needed.

Whether these unwarranted intrusions on the confidentiality of the physician-patient relationship are necessary for fiscal or other reasons is moot. There are many other considerations. What is important is that many time-honored and correct doctor and patient rights are being "managed" by people who know nothing of the way good medicine is done and most significantly, of the personal relationship which obtains between doctors and patients. Patients don't like it and doctors don't like it.

So let us change it. There is one sure way. Unions do it all the time. Let the Mississippi Medical Association call a general strike of all physicians, including resident physicians in the teaching hospitals. I can assure you that after there have been no hospital admissions, emergency surgery, office visits, or other medical care for a day or so, and several people have died, the Governor will call a quick meeting of the Legislature and they will repeal the terribly unrighteous elements of the present state and other health plans in Mississippi.

"Oh," I hear people exclaim, "doctors don't do that. They have a code of ethics." All the other groups which strike have one too. That includes nurses, teachers, and bus drivers. The Hippocratic Oath says "whatever house I enter . . ." It does not compel a doctor to enter the house or provide any care. A state license gives legal permission to provide health care. It does not force a doctor to do it.

(Continued on page 369)

LETTERS, COMMENTS or QUERIES.... The Editors of *The Journal MSMA* invite members of the MSMA and others to comment for publication on any material that appears in the publication or on other current medical issues. If you have a letter, comment or query, please send it to: The Editors *Journal MSMA*, PO Box 5229, Jackson, MS 39296-5229. The views expressed in this section are those of the indicated author and are not expressions of the views, or officical policies of The MSMA.

#### LETTERS /Continued

"Well then," I hear others say, "suppose it was you or one of your loved ones who died for lack of medical care." Sorry. No deal. If I believe what I am saying, I must be willing to stand by the consequences.

People who provide a private service - doctors, attorneys, accountants, psychologists, engineers, artists, priests - many others - can and should refuse

to enter into any contract which is not in the interest of how they perceive their profession or those they seek to serve.

I am suggesting that they do it! It won't take long. People will not stop going to doctors. But doctors can stop working. They have the power to restore what must be. Do it now!

L. Judson Farmer, Retired Professor
Communicative Disorder
Department of Surgery
University of Mississippi Medical Center
Jackson, MS



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#### Mississippi Foundation For Medical Care

#### Remembering 'Dr. Mc'

The bad news circulated quickly throughout the Foundation offices November 17: Dr. Jim McLain had died earlier that morning at the Walthall County Hospital in Tylertown of heart failure.

As the word spread, one staff member remembered his plans to call "Dr. Mc" that week; another two had plans for a holiday visit with him the following weekend. The lines of communication stayed open between his home in Tylertown and the Foundation family. The news brought to the staff a mood that was naturally very sad, very somber.

Then the memories of his time at the Foundation began to revive and bring smiles as the special times were remembered. And the memory of those times cheered everyone a little, as each remembered the special man and physician Dr. Mc was, how varied and versatile his life had been and how he had lived it to the fullest.

Dr. McLain was named medical director of the Foundation in 1986. He had served as a review physician and longtime Foundation supporter during the early formative years of the peer review organization.

His private practice which resulted in his being a much loved physician by thousands of patients included 31 years at Tylertown, following earlier years in Morton.

Dr. Mc, a native of Gilmer, Texas, graduated from Central High School in Jackson. He studied at Davidson College in North Carolina and Millsaps College in Jackson.

A great storyteller, he was fond of recalling an adventure

when he and a 14-year-old classmate at boarding school each told his respective parents that he had been invited to share the holidays at the other's home. The innovative young men pooled their resources and traveled to Washington, D. C., touring museums and national landmarks. It was an educational, historical holiday, but unfortunately not known or blessed by their parents. Only the mothers' thank-you notes disclosed the discrepancy in the lads' plans, and it was too late then.

His adventuresous spirit stayed with him and makes his life sound like a movie script. He started flying as a teenager and was licensed to fly at 15. Age 17 saw him joining the Air Force in World War II. He piloted a B-29 bomber and was involved in two crashes in the war, one of which left him in the hospital for 18 months. He later served as a major and flight surgeon in the Air Force Medical Corps in Korea.

After World War II, he re-

turned to college, with plans to study aeronautical engineering. However, he realized that jobs were scarce in that field at the time, and he switched to medicine, graduating from Louisiana State University Medical School and interning at City Hospital in Mobile.

Aviation was his great love. Friends remember that he flew both in the air and on the ground. He was the proud owner of the fifth Thunderbird to come off the assembly line in 1955. Other prizes were his red Luscombe, his first private aircraft as well as a Cessna 182, his last plane, before ill health forced a change in his lifestyle. Such hobbies as snorkeling and scuba diving, as well as some car racing, were given up, but the greatest sacrifice was his flying. Once he had taken off for Jackson from Tylertown and from his aircraft saw his son and friends driving away from school a little too early. They were bewildered at his knowing their



Dr. James Louis McLain- 'Dr. Mc'

JOURNAL MSMA

whereabouts at the time.

His interests were many and varied, including good food, fine wine and classical music. His extensive collection of tapes, recordings, videos and books called for more than the usual work and packing when he moved.

He performed in musicals, choirs and community theater. He shared his talents for Christmas programs at the Foundation, and staff members particularly recall the highlight one year— his professional rendition of Frosty the Snowman, complete with top hat.

He was named "Mississippi's Man of the Year" in 1954 by the Jaycees, no doubt because of his work as a dedicated physician but also because of many hours of service with the Explorer Scout program. His years of camping experience when he lived out West were invaluable for the program, which is credited in part for bringing him together with his son, Stanley, who filled a very special place in his life.

Dr. Mc enjoyed evoking startled glances from acquaintances by mentioning that he had always been a bachelor and then bragging like any proud father of his son. Through the Scouting program, boys ages 14 and above from the Baptist orphanage in Jackson stayed with Tylertown families during the summer and Christmas holidays. Dr. Mc led the program in numerous ways, but did not keep any of the boys because of his physician's schedule. However, one Christmas a ten-vear-old boy did not have a family, and finally the busy doctor agreed to host him. A twoweek visit was all it took to cinch a father-son feeling, and special adoption arrangements were made. Dr. Mc and Stanley McLain, who already felt like father and son, were a permanent family.

Dr. Mc's greatest love was his family, his son Stanley, daughter-in-law Donna and grandsons Scott and Benjamin of Hattiesburg; his mother, Mrs. Lenora Flinn McLain, and his sister, Mrs. Diana Wilkins, both of Brookhaven.

Before he left the Foundation in 1990 because of his health, Dr. Mc presented a program in Tylertown. The National Guard Armory was filled as friends, former patients, and hospital staff thronged to the event waiting in line to shake his hand, to hug him, to express love and their missing him.

"Dr. McLain contributed a great deal to the quality of medical care in our state," said Dr. James S. McIlwain, who followed him as medical director at the Foundation. "His devotion to his patients and his dedication to the highest quality of care are certain to be remembered."

According to executive director Fred A. Parish, "We stayed in touch with Dr. Mc when he retired, and we will miss him very much. We have had great losses in the past months with the deaths of Dr. Arthur Derrick, Dr. J. T. Davis, Dr. Moncure Dabney and now Dr. McLain. These men were pivotal in their support of the Foundation when it began in the 1970s. As the Foundation underwent changes, they continued to work with and support it. They have meant a great deal to the staff and to my family and me. They will all be greatly missed."

Services for Dr. McLain, who was 68, were held Saturday, November 19, at Capps Funeral Home in Tylertown, with burial in Hillcrest Memorial Garden.



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#### **Medical Assurance Company of Mississippi**

#### Choosing a Malpractice Insurance Company

With all the conflicting messages you receive from insurance companies, how do you decide which one will handle your medical professional liability insurance?

It is imperative that you consider not only price, but also what you get in return for your premium dollars. If you have never been sued, you probably have not given much thought to the support your insurer provides. Unfortunately, the odds show that at some time during your practice this support -- or lack of support -- will mean a great deal to you.

Following are a few important questions you should ask, whether you are a first time purchaser of malpractice insurance or you are considering changing companies.

#### How does the company operate?

Malpractice insurance companies operate in one of two ways. They are either profit-driven, and all decisions boil down to how they affect the company's bottom line; or the company's reason for existence is to protect the physicians they serve. The importance of this basic philosophy is reflected in the next point.

What rights do I have? Always ask if the company has a "consent to settle" policy, because many do not. With a consent to settle policy, you are involved in the settlement or defense of a claim against you, rather than having decisions handed down by insurance executives without your consent.

Who makes decisions regarding my coverage? Is the company controlled by insurance executives and/or physicians in another state, or are decisions made by Mississippi physicians who are familiar with the problems you face in your practice every day? Will you be able to have input where

these decisions are concerned and the right to appeal committee decisions?

Will I be dealing with insurance salesmen, or can I meet face-to-face with the staff members who will handle any problems I might have? Are they easily accessible? If a company promises you local peer review, ask for a list of the Mississippi physicians who serve on these committees. You won't want to be insured by a company that will accept all comers...no matter how cheap their rates may be initially.

How many cases have they tried in Mississippi? How many claims files are closed without indemnity payments? This will tell you a great deal about whether the company aggressively defends physicians, or whether they tend to take the "cheapest way out."

Do they <u>really</u> provide risk management services? Everyone has flashy brochures promising risk management support. Ask them how many workshops they have conducted in Mississippi and where their risk management personnel are located. This will give you an idea about whether they are here to serve you or simply to make a profit.

What commitment have they shown to Mississippi physicians? Do you only see company representatives when they are trying to sell you something, or do they take an active part in the medical community?

How many <u>Mississippi</u> doctors do they insure? Ask for letters of recommendation from physicians in your area. Talk to your peers who have been through the litigation process. Who would they recommend to you?

When it comes time to decide where your malpractice dollars are best spent, remember that malpractice coverage is not something you pay as little as possible for and then forget about. Place your business with the company that offers you the greatest stability and protection at a fair price.

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#### **Medical Organization**

# Services Held for *Journal MSMA* Editor Emeritus W. Moncure Dabney, MD

William Moncure Dabney, MD, died of a cerebral hemorrhage Thursday, November 10, at his home. He was 83.

Services were held Saturday, November 12, at Holy Trinity Episcopal Church with burial in Crystal Springs Cemetery.

Dr. Dabney, a Crystal Springs native, began practicing medicine in Baldwyn after graduation from the University of Tennessee Medical School and an internship at John Gaston Hospital in Memphis. He was a World War II Army Medical Corps veteran, serving in South Carolina and the South Pacific and attaining the rank of lieutenant colonel.

He practiced medicine in Crystal Springs for 46 years beginning in 1946 until his retirement on December 31, 1991. He providing medical services for four generations of families and delivered some 4500 babies.

Dr. Dabney was editor of the Journal of the Mississippi State Medical Association for 25 years beginning in 1961. In 1984 when he was designated editor emeritus, the Association's House of Delegates commended his dedicated and distinguished service because of the many awards and recognitions the Journal received during his tenure. Dr. Dabney first served as associate editor of the publication having been elected to the post during the Journal's

formative stages. During his tenure as editor, he wrote dozens of editorials, reviewed countless scientific manuscripts, and participated in hundreds of decisions to expand the publication's services.

Dr. Dabney's editorials in the Journal MSMA dealt with a variety of timely topics, including the growing body of medical knowledge and its effects; preserving the art of medicine as well as expanding the science; the threat of pollution; the demands of a growing population on limited resources; and the role of physicians within the community. Those who know his record of service realize that he has been much more than an advocate of physicians participation in civic and community affairs. He was an example.

"He was a good Samaritan to many people in this community for many years," said his daughter, Pamela Dabney Truett of Jackson.

Besides writing for the Journal MSMA, Dr. Dabney was a regular writer of letters to the editor of The Clarion-Ledger, and his last appeared in the paper on the Tuesday before his death.

"He had quite a knack for the written word and was a very articulate and opinionated person," Mrs. Truett said. "He was just a very moral, upstanding person."

A warden for Holy Trinity Episcopal Church, Dr. Dabney had served as a Sunday school teacher. He was a past president of the Lions Club and a member of the Crystal Springs Men's Garden Club. His hobby was flower gardening.

Mrs. Truett said her father was one of the founding members of the men's garden club and had had beautiful roses as long as he was able to care for them.

"I can remember from when I was a child that he was always interested in gardening," Mrs. Truett said. "I can remember going out with him on calls— house calls— in the country, and he would always go out and admire his patients' flowers. He would get seeds and cuttings and bring them back and plant them."

Dr. Dabney was a member of the American Academy of Family Physicians and past president of the Mississippi Academy of Family Practice and the South Central Medical Society.

In June of 1972, he was appointed to the State Board of Health, serving as president in 1979. In 1974 he was named to FLEX, the National Board of Medical Licensure serving for four years. Besides editing the MSMA Journal, he served on many MSMA committees and councils.

Other survivors include: wife, Betty; daughter, Greer "Gigi" Dabney Smith of Ridgeland, sisters, Ella Nora Campbell and Susan Rawls, both of Crystal Springs; and four grandchildren and two great grandchildren.

# Dabney Memorial Established at Chautauqua

Because of his great love of gardening, a memorial fund in honor of Dr. W. Moncure Dabney has been established at the Chautauqua Arboretum and Botanic Gardens in Crystal Springs. Contributions for the W. Moncure Dabney, MD, Memorial may be sent to Friends of Chautauqua, % Mary Connor, 1106 Rolling Hills Drive, Crystal Springs, MS 39059. All donations are tax deductible.

Located on the grounds of the historic Chautauqua Memorial

Park, Chautauqua Arboretum and Gardens is used as a center for the promotion of resource conservation, outdoor education and related environmental programs.

The development of Chautauqua Arboretum and Gardens began in 1989 and is scheduled to be completed in three phases. Phase I was the construction and renovation of the Visitors Center; phase II involved the construction and landscaping of the parking area. Currently, phase III includes development of the grounds itself.

The historical significance of the Chautauqua Arboretum and Gardens site is an eminent feature. The word "chautauqua" is a pre-colonial Iroquois Indian term which referred to a legend about a small boy leading a blind man with a rope. The term came into use again when the first Chautauqua Assembly was formed in eastern New York in the late 1800's as an educational institution seeking to lead the spiritually and intellectually blind.

The Crystal Springs Chautauqua Assembly was active from 1892 to 1917 during which time it was frequented by noteworthy scholars, evangelists and actors of the period. In 1909, delegates from five cities convened at the site of the present amphitheater to form the first Mississippi Conference of Parents and Teachers (PTA).

Chautauqua Memorial Park is a public park located in Crystal Springs between Interstate 55 and Highway 51. It comprises 60 acres of wooded rolling hills, including a 30 acre lake and flowing springs.

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#### Dr. Bobby Spell Receive Golden Arrow Award

Dr. Bobby Gene Spell of Jackson, a Georgetown native, is one of three individuals who was honored by Mississippi College with the "Order of the Golden Arrow" Award.

The three, who have had out standing careers in the fields of teaching, medicine and insurance, were honored by the National Alumni Association at homecoming on Oct. 22 during the annual alumni luncheon held at the A.E. Wood Coliseum.

Dr Spell is a surgeon with the Mississippi Methodist Rehabilitation Center and consulting physician at area hospitals. Other recipients are Dr. Charles M. Tolbert of Waco, Texas, professor of sociology in the Department of Sociology, Anthropology, Social Work and Gerontology at Baylor University, and Jimmy Howard Jenkins Jr. of Clinton, executive vice president of Mississippi Farm Bureau Insurance Company, Jackson.

The award honors the trio for their dedication to Mississippi College and their professional achievement in their chosen fields. The award is one of the highest given by the Alumni Association.

Dr. Spell received a bachelor of science degree from Mississippi College in 1954. He then entered the University of Mississippi Medical School in Jackson and was awarded a medical degree in 1959.

He interned at the University of Texas Branch Hospital at Galveston, Texas, before becoming a resident in surgery at Mississippi Baptist Medical Center in Jackson. He has also served as a resident in orthopaedic Surgery at the University of Arkansas Medical Center in Little Rock and

the Children's Hospital in the same city.

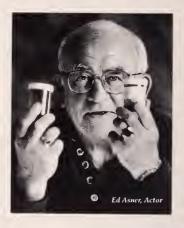
Dr. Spell has served on the medical staff of most of the major hospitals in the metro Jackson area and is past chief of orthopaedics at The Veterans' Administration Hospital in Jackson. He is also past director of the Rehabilitation and Amputee Clinic at the VA Hospital.

He has served in numerous other capacities in hospitals throughout the area and has been a longtime consultant and team physician for Mississippi College. He has served in a similar capacity at Belhaven College. Dr. Spell was president of the medical staff of Mississippi Methodist Hospital and Rehabilitation Center from 1985 to 1988.

He has conducted a number of seminars and clinics dealing with emergency care and transportation, sports injuries and arthroscopy, amputation, orthopaedic impairment in the elderly automated percutaneous lumbar discectomy and other topics.

Dr. Spell holds membership in the American Academy of Orthopaedic Surgeons, Jackson Chapter of Mississippi State Orthopaedic Society, Mid-America Orthopaedic Association, Southern Orthopaedic Association, Central Medical Society, the Mississippi State Medical Association, the American Medical Association, Southern Medical Association, Southern Medical Association and National Association of Disability Evaluating Physicians.

# Attention: Physicians



# Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

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"What other prescription and nonprescription medicines are you taking?"

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A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

ANGEL, MICHAEL F., Jackson. Born Pittsburgh, PA, April 13, 1952; MD, University of Rochester School of Medicine, Rochester, New York 1978; interned and surgery residency, Yale New Haven Hospital, New Haven, CT, 1978-83; otolaryngology residency, University of Pittsburgh School of Medicine, Pittsburgh, PA, 1983-85; one year plastic surgery fellowship, St Vincents Hospital, Melbourne, Australia and one year University of Virginia, Charlottesville, VA; elected by Central Medical Society.

Brannan, Donald P., Jackson. Born Atlanta, GA, May 23, 1956; MD, Medical College of Georgia, Augusta, GA, 1982; interned one year, same; internal medicine residency, Naval Hospital Oakland, CA, 1985-87; gastroenterology fellowship, University of North Carolina, Chapel Hill, NC 1989-92; elected by Central Medical Society.

BUECHLER, KURT A., Jackson. Born Detroit, MI, August 23, 1963; MD, Michigan State University School of Medicine, East Lansing, MI, 1989; psychiatry residency, Mayo Graduate School of Medicine, Rochester, MN, 1989-92; child & adolescent psychiatry residency, same, 1992-94; elected by Central Medical Society.

Burton, Elmertha, Born Greenville, MS, July 12, 1948; MD, Meharry Medical College of Medicine, Nashville, TN, 1970; ob-gyn residency Providence Hospital, Southfield, MI, 1974-78; elected by Delta Medical Society.

CAREY, F. THOMAS, JR., Natchez. Born Chatsworth, GA, October 15, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1989; Ob-gyn residency, Sparrow Hospital, Michigan State University, Lansing, M1, 1989-93; elected by Homochitto Valley Medical Society.

COFRANCESCO, SIMON, McComb. Born New Haven, CT, February 20, 1960; MD, University of Health Science College of Osteopathic Medicine, Kansas City, MO, 1985; interned and internal medicine residency, Bay State Medical Center, Tufts University School of Medicine, Springfield, MA, 1986-92; gastroenterology fellowship, The Long Island College Hospital, Brooklyn, NY, 1992-94; elected by South Central Medical Society.

CRENSHAW, A. N., III, Jackson. Born Chunky, MS, April 30, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1980; family practice residency, St. Francis Hospital, Memphis, TN, 1980-81; elected by Central Medical Society.

D'ANGELO, MARC SCOTT, Hattiesburg. Born Philadelphia, PA, May 21, 1952; MD, Autonomous University of Guadalajara, Mexico 1980; one year internship, University of Cincinnati, OH; neurology residency, Vanderbilt University, Nashville, TN, 1986-87; Neuropathology fellowship, Tho-

mas Jefferson University, Philadelphia, PA, 1982-83; Neurodiagnostics fellowship, Vanderbilt University, Nashville, TN, 1987-88; elected by South Mississippi Medical Society.

DIAZ, MICHAEL J., Gulfport. Born Biloxi, MS, August 3, 1960; MD, Tulane University School of Medicine, New Orleans, LA., 1985; interned one year, Keesler Medical Center, Keesler AFB, Biloxi, MS; radiology residency, Wilford Hall Medical Center, Lakeland AFB, TX, 1988-92; elected by Coast Counties Medical Society.

ELKINS, STEPHANIE L., Jackson. Born Asheville, NC, June 14, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; internal medicine residency, University Medical Center, Jackson, MS, 1987-91; hematology-oncology fellowship, same, 1991-93; elected by Central Medical Society.

ENGER, ERIC W., Hattiesburg. Born Pascagoula, MS, December 9, 1960; MD, University of Mississippi School of Medicine, Jackson, MS, 1987; internal medicine residency, St Louis University School of Medicine, St. Louis, MO, 1987-90; cardiology fellowship, Ochsner Foundation Hospital, New Orleans, LA, 1987-94; elected by South Mississippi Medical Society.

Evans, Jeffery N., Oxford. Born Jackson, MS, October 31, 1962; MD, University of Mississippi School of Medicine, Jackson, MS,

#### New Members *Icontinued*

1988; internal medicine residency, University Medical Center, Jackson, MS, 1988-1991; pulmonary diseases fellowship, same, 1991-93; elected by North Mississippi Medical Society.

FISHER, J. KEITH, Laurel. Born Jackson, MS, April 20, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1990; one year internship, University Medical Center, Jackson, MS; anesthesiology residency, Vanderbilt University School of Medicine, Nashville, TN, 1991-92 and University Medical Center, Jackson, MS, 1992-94; elected by South Mississippi Medical Society.

HAYDEN, CHARLES Ross, Columbus, Born Birmingham, AL, May 8, 1960; MD, University of Alabama School of Medicine, Birmingham, AL, 1985; psychiatry residency, same, 1985-89; elected by Prairie Medical Society.

Henderson, C. Hardy, Hattiesburg. Born Waynesboro, MS, December 31, 1953; MD, University of Mississippi School of Medicine, Jackson, MS, 1982; family medicine internship, Medical College of Georgia, Augusta, GA, 1982-83; anesthesiology residency, University Medical Center, Jackson, MS, 1991-94; elected by South Mississippi Medical Society.

Johnson, Samuel Andrew, McComb. Born Raleigh NC, October 11, 1963; MD, East Carolina University School of Medicine, Greenville, NC, 1989; interned and internal medicine residency, University of Tennessee College of Medicine, Memphis, TN, 1989-92; gastroenterology fellowship, Medical College of Ohio

at Toledo, OH, 1992-94; elected by South Central Medical Society.

Massony, Barbara N., Gulfport. Born New Orleans, LA, July 5, 1939; MD, Louisiana State University School of Medicine, New Orleans, LA, 1969; radiology residency, Charity Hospital, New Orleans, LA, 1970-73; elected by Coast Counties Medical Society.

McKay, Michael A., Gulfport. Born Baton Rouge, LA, October 1, 1963; MD, Louisiana State University School of Medicine, Shreveport, LA, 1989; interned one year, same; ob-gyn residency, University of Maryland School of Medicine, Baltimore, MD, 1990-93; elected by Coast Counties Medical Society.

MILLER, MARGARET E., Jackson. Born Biloxi, MS, March 18, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine, University Medical Center, Jackson, MS, 1991-94; elected by Central Medical Society.

Nading, John H., Tupelo. Born Winston Salem, NC, November 27, 1951; MD, Vanderbilt University School of Medicine, Nashville, TN, 1977; pediatric internship, Grady & Emory Hospital, Atlanta, GA, 1977-78; pediatric residency, Naval Air Station, Bethesda, MD, 1980-82; neonatology fellowship, Uniformed Health Services University of the Health Sciences, Bethesda, MD, 1982-84; elected by Northeast Mississippi Medical Society.

Norris, Dale W., Jackson. Born Stuttgart Germany, June 26, 1956; MD, University of Tennessee College of Medicine, Memphis, TN, 1984; internal medicine internship, same, one year; elected by North Mississippi Medical Society.

OSBORNE, C. MICHAEL, Jackson. Born Yazoo City, MS, November 26, 1962; MD, University of Mississippi School of Medicine, Jackson, MS 1988; interned one year, University Medical Center, Jackson, MS; otolaryngology residency, same, 1990-94; elected by Central Medical Society.

OVERBECK, DANIEL T., Long Beach. Born Springfield, PA, April 23, 1954; MD, Hahnemann Medical College & Hospital, Philadelphia, PA, 1981; internal medicine residency, University of Southern California Medical Center, Los Angeles, CA, 1981-84; elected by Coast Counties Medical Society.

REID, R. KIRK, Jackson. Born Columbus, MS, May 4, 1963; MD, University of Mississippi School of Medicine, Jackson, MS, 1990; anesthesiology residency, University of Texas Medical School, Galveston, TX, 1990-94; elected by Central Medical Society.

Russell, Thomas Geral, Jr., Jackson. Born San Antonio, TX, September 27, 1955; MD, University of Mississippi School of Medicine, Jackson, MS, 1985; family medicine residency, University of Alabama Medical School at Birmingham, AL, 1985-88; elected by Central Medical Society

SHULTES, PHILIP D., Oxford. Born Orange, NJ, April 4, 1964; MD, Pennsylvania State University College of Medicine, Hershey, PA, 1990; interned and anesthesiology residency, University of Florida College of Medicine, Gainesville, FL, 1990-94; elected by North Mississippi Medical Society.

SICARD, DAVID L., Hattiesburg, Born New Orleans, LA., April 29, 1959; MD, Louisiana State University School of Medicine, New Orleans, LA, 1990; internal medicine internship, Ochsner Foundation Hospital, New Orleans, LA, 1990-91; anesthesiology residency, University of Florida College of Medicine, Gainesville, FL, 1991-94; elected by South Mississippi Medical Society.

SMITH, HOWARD L., Ocean Springs. Born Oklahoma City, OK, April 13, 1955; MD, University of Oklahoma School of Medicine, Oklahoma City, OK, 1985; interned and neurosurgery residency, same, 1985-91; elected by Singing River Medical Society.

TRINCA, DOMINIC, Greenville. Born New York, January 21, 1960; MD, Albany Medical College of Union University, Albany, NY, 1990; obgyn residency, Brookdale Hospital, Brookdale, NY, 1990-94; elected by Delta Medical Society.

TURNER, JOHN L., IV, Greenville. Born Greenville, MS, September 7, 1959; MD, Tulane University School of Medicine, New Orleans, LA, 1988; anesthesiology residency, Yale University School of Medicine, New Haven, CT, 1989-92; cardiothoracic anesthesiology fellowship, same, 1992-93; elected by Delta Medical Society.

WALKER, ARMIE W., Vicksburg. Born Moorhead, MS, August 23, 1959; MD, University of Mississippi School of Medicine, Jackson, MS, 1986; ob-gyn residency, Louisiana State University School of Medicine Medical Center, Shreveport, LA, 1986-90; elected by West Mississippi Medical Society.

WILE, ALAN GREGORY, West Point. Born Detroit, MI, October 9, 1947; MD, University of Michigan School of Medicine, Ann Arbor, MI, 1972; surgery residency, University of California Medical Center, Westwood, CA, 1972-79; surgery fellowship, same 74-76 and MD Anderson Hospital, Houston, TX 1979-80; elected by Prairie Medical Society.□

## **Deaths**

BAINES, T. A., Jackson. Born Florence, MS, August 7, 1911; MD, Tulane University School of Medicine, New Orleans, LA, 1936; interned Alington Memorial Hospital, Philadelphia, PA; died October 12, 1994, age 83.

SHARPE, GUY P, JR., Ocean Springs, MS, July 2, 1921; MD, Duke Medical School of Medicine, Durham, North Carolina, 1947; interned one year, Baptist Memorial Hospital, Memphis, TN; died October 1, 1994, age 73.

STONE, ORVILLE P., Ripley. Born Ripley, MS, September 1, 1915; MD, Tulane University School of Medicine, New Orleans, LA, 1941; interned one year, Charity Hospital New Orleans, LA; died September 26, 1994, age 79.

THE PUCKETT GROUP, PA AND PUCKETT LABORATORY announce the association of

Nasir Amra, M.D. Roger Arhelger, M.D. JOHN P. (JACK) JARRELL, M.D. KURT KRATZ, M.D.

in the practice of Clinical and Anatomical Pathology

Nasir K. Amra, Roger Arhelger, John P. (Jack) Jarrell and Kurt Kratz have associated with The Puckett Group, P.A., in the practice of Clinical and Anatomical Pathology, 4200 Mamie Street, Hattiesburg.

Richard B. Ellison, Jr., has associated with Lakeland Radiologists in the practice of Diagnostic and Interventional Radiology, 971 Lakeland Drive, Suite 420, Jackson.

Sandor Feldman, professor of pediatrics and director of pediatric infectious diseases at the University of Mississippi Medical Center (UMC), has been named co-editor-in-chief of *High Titre*, a new publication for Connaught Laboratories. The publication will be a quarterly, 12-page review of immunization practice for the practitioner, devoted to both pediatric and adult vaccines.

Richard J. Field, Jr., of Centreville, has received the C. D. Taylor Presidents' Award presented by the Tulane Medical Alumni Association for outstanding service to medicine in one's community.

J. Edward Hill a family practice physician in Hollandale was elected President-Elect of the Southern Medical Association (SMA) for 1994-95 during the Associations's 88th Annual Scientific Assembly held in Orlando, Florida, November 3-6.

Candace E. Keller, of Hattiesburg, a co-chair of the AMA Advisory Panel on Women Physician Issues, recently attend the Women Physician Leaders Summit which was sponsored by the Advisory Panel and included women medical leaders from organizations nationwide.

Thomas Puckett of Hattiesburg was recognized recently by the College of American Pathologists for his outstanding service to the College as State Commission for Mississippi.

Joe Robinson, a Jackson dermatologist, recently spoke at the MS Baptist Fitness Center on the topic, How Arthritis Medicine Can Affect the skin and Ways to protect the Skin from the Effects of Swimming Pools, Hot tubs and the Environment.

Henry B. Tyler, of Jackson, was recently re-elected to the Board of Governors of the American College of Surgeons as a Governorat-Large from Mississippi.

Alexander Wong has associated with the Internal Medicine Clinic of Laurel in the practice of Oncology, 1203 Jefferson Street, Laurel.

# Physicians' Recognition Award

I B

Three MSMA members were named recipients of the AMA Physicians Recognition Award in September and October. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL
MEDICAL SOCIETY
James S. McIlwain, MD

COAST COUNTIES
MEDICAL SOCIETY
Thomas E. Benefield, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY William B. Strong, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the AMA Office of Physician Credentials and Qualifications: (312) 464-4672.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

## Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) The original and one duplicate should be submitted. The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

REVIEWING PROCESS. Each manuscript is reviewed by the Editor and/ or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

TITLE PAGE should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

ABSTRACT, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

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Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials,

Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

REFERENCES must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

#### Journals

[1] Author(s). Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] Title of article. Capitalize only the first letter of the first word. [3] Name of Journal followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] Year of publication; [5] Volume number: Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] Inclusive page numbers. Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. Am J Clin Pathol 1979;71:680-692.

#### Books

[1] Author(s). Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] Title, Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] Edition number, [4] Editor's name. [5] Place of publication, [6] Publisher, [7] Year, [8] Inclusive page numbers. Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

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TABLES should be self-explanatory and should supplement, not duplicate, the text. Each should be typed on a separate sheet of paper, be numbered, and have a brief descriptive title.

ACKNOWLEDGMENTS are the author's prerogative; however, acknowledgment of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

GALLEY PROOFS will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs.

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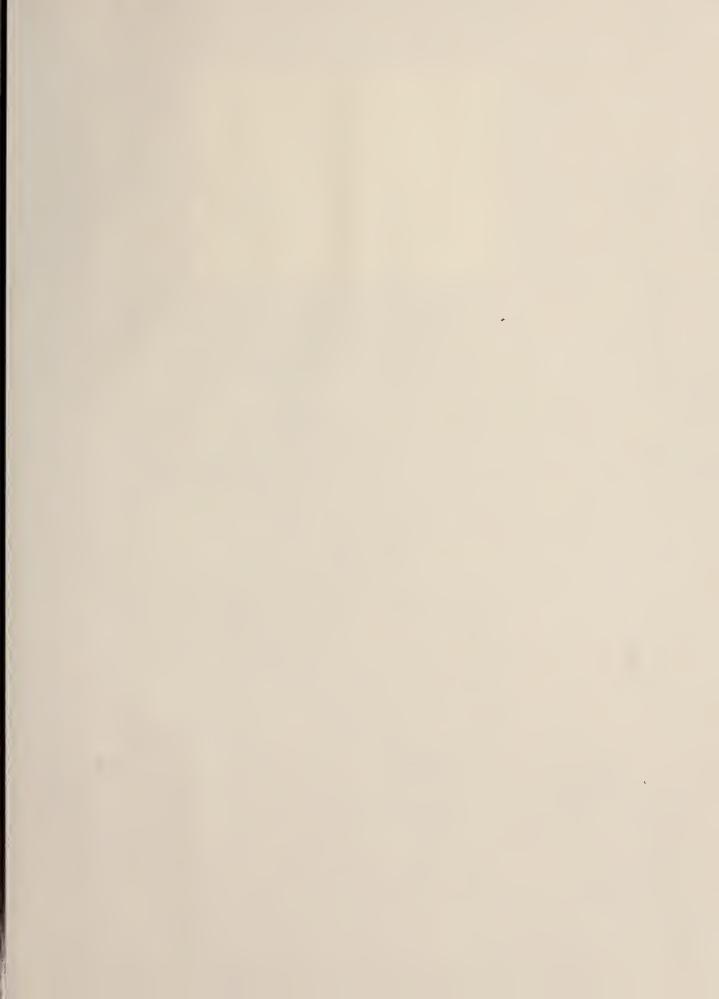
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